ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION
DIVISION OF BUSINESS AND FINANCE
SECTION A: CONTRACT AMENDMENT

1. AMENDMENT NO:	2. CONTRACT NO.:	3. EFFECTIVE DATE OF AMENDMENT:	4. PROGRAM
10	**YH03-0032 ADHS # HS461371**	**October 1, 2008**	**DHCM**

4. CONTRACTOR'S NAME AND ADDRESS:

Arizona Department of Health Services
Children's Rehabilitative Services
150 North 18th Avenue, Suite 330
Phoenix, AZ 85007

6. PURPOSE OF AMENDMENT: To amend Section B, D and Attachment F.

7. THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

A. Section D. *Program Requirements*, amended to rearrange paragraph order.

B. Section D. Paragraph 57, *Reinsurance*, added new paragraph and requirements. Please see body for detail.

C. Attachment F. *Periodic Report Requirements*, amended to adjust due dates for new contract year period October 1 through September 30.

NOTE: Please sign and date both and return one to:

Jamey Schultz, Sr. Procurement Specialist
AHCCCS Contracts and Purchasing
701 E Jefferson Street
Phoenix AZ 85034

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT.

IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT

9. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	10. SIGNATURE OF AHCCCS CONTRACTING OFFICER**:**
TYPED NAME: **ANN FROIO**	**MICHAEL VEIT**
TITLE: **PROCUREMENT ADMINISTRATOR**	**CONTRACTS & PURCHASING ADMINISTRATOR**
DATE:	DATE:

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SECTION B: CAPITATION RATES

CRSA shall provide services described in this contract. In consideration for these services, CRSA will be paid as described in Section D: Program Requirements, Paragraph 53 Compensation. For the term October 1, 2008 through September 30, 2009, CRSA will be paid the capitation rates shown below for CRS eligible AHCCCS members, subject to review by the Joint Legislative Budget Committee and the Centers for Medicare and Medicaid.

Subcontractor	Risk Category		
	High	Medium	Low
APIPA	$1,051.16	$472.90	$219.97

SECTION C: DEFINITIONS

ACOM	*AHCCCS Contractor Operations Manual*, available on the AHCCCS website at www.azahcccs.gov.
ADHS	Arizona Department of Health Services.
ADJUDICATED CLAIMS	Claims which have been received and processed by the Contractor which resulted in a payment or denial of payment.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity
AHCCCS	Arizona Health Care Cost Containment System as defined by ARS §36-2901.
AHCCCS CARE	Eligible individuals and childless adults whose income is less than 100% of the FPL, and who are not categorically linked to another Title XIX program. Also known as "NON MEDICAL EXPENSE DEDUCTION MEMBER (NON-MED)"
AHCCCS MEMBER	See "MEMBER."
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by ARS §36-2932 et seq.
AMPM	The *AHCCCS Medical Policy Manual.*
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C)	State regulations established pursuant to relevant statutes. For purposes of this contract, the relevant sections of the AAC are referred to throughout this document as "AHCCCS Rules."
A.R.S	Arizona Revised Statutes.
BBA	The Balanced Budget Act of 1997.
BIDDER'S LIBRARY	A repository of manuals, statutes, rules and other reference material located at AHCCCS. A limited, virtual library is located on the AHCCCS website at www.azahcccs.gov.
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
CAPITATION	Payment to contractor by AHCCCS of a fixed monthly payment per person in advance for which the contractor provides a full range of covered services as authorized under ARS § 36-2942 and § 36-2931.
CLAIM DISPUTE	A dispute filed by a provider or a health plan/program contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by ARS § 36-2904.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department

	of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
CONTRACT YEAR (CY)	Corresponds to state fiscal year (Oct 1 through Sept 30).
CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with the stated contract requirements, AHCCCS statute and rules and Federal law and regulations. For purposes of this contract, CRSA and Contractor have the same meaning.
COPAYMENT	An amount which the member pays directly to a provider at the time covered services are rendered.
COVERED SERVICES	Health and medical services to be delivered by CRS which is designated in A.A.C. Title 9 Chapter 7 Article 4 et seq. and the AMPM. [42 CFR 438.210(a)(4)]
CRS	Children's Rehabilitative Services administered by ADHS, as defined in R9-22-102.
CRS ELIGIBLE	An individual who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS related services.
CRS RECIPIENT	A CRS recipient is a CRS eligible individual who has been enrolled in CRS, which allows the individual to participate in the CRS program.
CRSA	Children's Rehabilitative Services Administration.
CYE	Contract Year Ended; same as "CONTRACT YEAR".
DAYS	Calendar days unless otherwise specified in the text, as defined in R9-22-101.
DELEGATED AGREEMENT	A type of subcontract with a qualified organization or person to perform one or more functions required to be provided by the Contractor pursuant to this contract.
DIRECTOR	The Director of AHCCCS.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
ELIGIBILITY DETERMINATION	A process of determining, through a written application and required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or, c) serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. [42 CFR 438.114(a)]
ENCOUNTER	A record of a health care related service, submitted by CRSA and processed by AHCCCS, which is rendered by a provider registered with AHCCCS to a CRS recipient on the date of service, and for which a CRS subcontractor incurs any financial liability.
ENROLLEE	A Medicaid recipient who is currently enrolled with a health plan or program contractor.

	For purposes of this contract, see definition of Member. [42 CFR 438.10(a)]
ENROLLMENT	The process by which an eligible person becomes an enrollee of a health plan or program contractor.
FEDERAL FINANCIAL PARTICIPATION (FFP)	The Federal matching rate that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS as defined in 42 CFR 400.203.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HIPAA	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996.
IBNR	Incurred But Not Reported liability for services rendered for which claims have not been received.
KIDSCARE	Individuals under the age 19, eligible under the State Children's Health Insurance Program (SCHIP), in households with income at or below 200% FPL. All members, except Native American members are required to pay a premium amount based on the number of children in the family and the gross family income. Also referred to as Title XXI.
LIABLE PARTY	A person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
LIEN	A legal claim, filed with the County Recorder's office in the county in which a member resides and/or in the county an injury was sustained, for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, utilization management and the coordination of care.
MANAGEMENT SERVICES AGREEMENT	An agreement with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.
MANAGEMENT SERVICES	An entity to which the Contractor delegates the comprehensive management and administrative services necessary for the operation of the Contractor
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
MATERIAL OMISSION	Facts, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MAJOR UPGRADE	Any upgrade or changes that may result in a disruption to the following: Loading of contracts, providers, members, issuing prior authorizations or the adjudication of claims.

MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a state-operated medical assistance program for specified populations.
MEDICAL EXPENSE DEDUCTION (MED)	Title XIX waiver member whose family income exceeds the limits of all other Title XIX categories (except ALTCS) and has family medical expenses that reduce income to or below 40% of the FPL. MED members may or may not have a categorical link to Title XIX.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MEDICARE PART D EXCLUDED DRUGS	Medicare Part D is the prescription drug coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit are not covered by AHCCCS. Certain drugs that are excluded from coverage by Medicare continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over-the-counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D health plan's formulary are not considered excluded drugs, and are not covered by AHCCCS.
NOTICE OF APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
NPI	National Provider Identifier assigned by the CMS contracted national enumerator.
PERFORMANCE STANDARDS	A set of standardized indicators designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors. Specific descriptions of health services measurement goals are found in Section D, Paragraph 23, Quality Management,.
PMMIS	AHCCCS's Prepaid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized so that the member could alternatively be safely discharged or transferred to another location. 42 CFR 438.114(a)
POTENTIAL ENROLLEE	A Medicaid eligible recipient who is not enrolled with an acute care/ALTCS contractor [42 CFR 438.10(a)].
PRIMARY CARE PROVIDER/ PRIMARY CARE PRACTITIONER (PCP)	An individual who meets the requirements of ARS § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to ARS Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under ARS Title 32, Chapter 25, or a certified nurse practitioner licensed under ARS Title 32, Chapter 15.
PROVIDER	A person or entity that subcontracts with CRSA, or its delegate, to provide AHCCCS covered services directly to members.

REINSURANCE	A risk-sharing program provided by AHCCCS to CRSA for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RFP	Request For Proposal is a document prepared by AHCCCS, which describes the services required and instructs prospective Offerors about how to prepare a response (proposal), as defined in R9-22-101.
SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act. The Arizona version of SCHIP is referred to as "KidsCare." See "KIDSCARE."
SCOPE OF SERVICES	See "COVERED SERVICES."
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its divisions or subsidiaries that requires specific levels of service for administrative functions or services for the Contractor, specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract.
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that generally required by members. All CRS recipients are considered to be members with special health care needs.
STATE	The State of Arizona.
STATE FISCAL YEAR (FY)	The budget year-State fiscal year: July 1 through June 30.
STATE PLAN	The written agreements between the State and CMS which describe how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by CRSA with a provider of health care services who agrees to furnish covered services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for CRSA specifically related to fulfilling CRSA's obligations to AHCCCS under the terms of this contract, as defined in R9-22-101.
SUBCONTRACTOR	(1) A person, agency or organization to which CRSA has contracted or delegated some of its management functions or responsibilities to provide covered services to its members.; (2) A person, agency or organization with which CRSA has contracted or delegated some of its management/administrative functions or responsibilities (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS contract.

THIRD PARTY LIABILITY	See "LIABLE PARTY".
TITLE XIX MEMBER	A member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under the 1931 provisions of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
TITLE XIX WAIVER GROUP (TWG) MEMBER	All AHCCCS Care (Non-MED) and MED members who do not meet the requirements of a categorically linked Medicaid program.
TITLE XXI MEMBER	See "KIDSCARE."

[END OF DEFINITIONS]

SECTION D: PROGRAM REQUIREMENTS

INTRODUCTION

1. TERM OF CONTRACT

The term of this Contract shall begin upon signature of both parties through September 30, 2009. This contract shall be renewed on an annual basis. All contract extensions shall be through amendment.

2. ELIGIBILITY FOR SERVICES

CRS serves individuals with chronic and disabling or potentially disabling medical conditions who:

a. Are under the age of 21;
b. Are residents of Arizona;
c. Are citizens or qualified aliens;
d. Have a CRS medical condition in accordance with R9-7-202;
e. Require multi-specialty physician services or require specialty care which may be provided through the CRS service system; and
f. Require expertise which is best developed and maintained through a center of excellence system supported by CRS.

CRSA shall develop and maintain a policy that contains all medical eligibility criteria. CRSA must submit the policy by October 1, and any subsequent changes, to AHCCCS for review and approval prior to the implementation. CRSA shall ensure that each subcontractor is issued a copy of the policy. The CRSA policy shall be available on the CRSA website at: http://www.azdhs.gov/phs/ocshcn/crs/crs_az.htm, and must be updated as soon as practicable.

Referral: CRSA shall maintain a process for AHCCCS Health Plans/Program Contractors to refer members to CRS. CRSA shall make referral forms available to health plans/program contractors. CRSA shall, based on the diagnosis, determine CRS medical eligibility.

Disposition of Referral: Within fourteen (14) calendar days of receipt of a referral/application, CRSA must review the documentation provided to determine an applicant's eligibility for CRS. CRSA will use the PMMIS system as verification of Title XIX/XXI enrollment, age, residency and citizenship/qualified alien status. Possible dispositions of the referral are:

a. The applicant is eligible;
b. The applicant is not eligible;
c. Further information is needed to determine eligibility; or
d. A physical exam is needed to determine the presence of a CRS medical condition. The physical exam must be scheduled within 30 calendar days of the decision that the physical exam is needed.

Notification requirements:
These notification requirements apply any time that a determination regarding eligibility is made. The determination could be made within fourteen (14) calendar days of receipt of a referral/application or following the receipt of further information or a physical exam.

When an applicant is determined eligible for CRS, the following notices must be provided:

a. Notification to the applicant and referral source: Upon identification as a CRS member, CRSA shall notify the applicant and referral source of their eligibility for CRS.

b. Notification to AHCCCS: Upon identification of a member as a CRS recipient, CRSA shall notify AHCCCS via the Recipient Roster Reconciliation tape. AHCCCS will post a CRS indicator on Health Plan/Program Contractor enrollment notification file.
c. Notification to the Health Plan/Program Contractor: Upon identification of a member as a CRS recipient, CRSA shall notify the following to the recipient's health plan/program contractor:
    1). Assigned subcontractor (Contractor) name;
    2). Assigned CRS specialty clinic name(s);
    3). Recipient's CRS qualifying diagnosis(es); and,
    4). CRS enrollment date.

When an applicant is determined ineligible for CRS, the following notices must be provided:

i. Notification to the applicant: Upon determination that the applicant is not eligible for CRS, CRSA shall notify the applicant, in writing, of the denial, the reason for the denial and their appeal rights within fourteen (14) calendar days of the determination of ineligibility.

ii. Notification to the Health Plan/Program Contractor and referring physician: Upon determining that the member does not meet the medical eligibility requirement for participating in the CRS program, CRSA shall inform the referring physician and the applicable health plan/program contractor, in writing, of the denial and the reason for the denial within 5 working days of the denial.

If further information is needed to determine eligibility for CRS, the following notice must be provided:

a. Notification to the applicant and referral source: Upon determination that further information is needed to determine CRS eligibility, CRSA shall send a notice to the applicant and the referral source requesting the missing information be submitted within thirty (30) calendar days.

If a physical exam is needed to determine the presence of a CRS medical condition, the following notice must be provided:

a. Notification to the applicant: Upon determination that a physical exam is needed to determine the presence of a CRS medical condition, CRSA shall notify the applicant within fourteen (14) calendar days of receipt of a referral/application of the need for a physical exam, indicate a scheduled appointment date and time for the initial medical evaluation within thirty calendar (30) days of the notice, and inform that if the applicant does not show for a physical exam within ninety (90) days, the CRS application will be considered withdrawn.

Enrollment: Title XIX/XXI enrolled applicants shall be enrolled in CRS effective on the same date that the eligibility determination is made.

CRSA shall not deny or delay eligibility determination or delivery of services to AHCCCS eligible members due to issues related to CRSA's State funding.

3. RESERVED

4. RESERVED

5. RESERVED

6. RESERVED

7. RESERVED

8. MAINSTREAMING OF CRS RECIPIENTS

To ensure mainstreaming of CRS Recipients, CRSA shall take affirmative action so that recipients are provided CRS services without regard to payer source, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated. CRSA must take into account a recipient's culture, when addressing recipients and their concerns, and must ensure its subcontractors do the same.

Examples of prohibited practices include, but are not limited to, the following:

a. Denying or not providing a recipient any covered service or access to an available facility;
b. Providing to a recipient any covered service that is different, or is provided in a different manner, or at a different time from that provided to other recipients, other public or private patients or the public at large, except where medically necessary;
c. Subjecting a recipient to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a recipient in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and,
d. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental handicap of the participants to be served.

If CRSA knowingly executes a subcontract with a provider or entity with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract act to discourage the full utilization of services by some recipients); CRSA will be in default of this contract.

If CRSA identifies a problem involving discrimination by one of its subcontractors, it shall promptly intervene and implement a corrective action plan. Failure to take prompt corrective measures may place CRSA in default of its contract.

9. TRANSITION OF RECIPIENTS

CRSA shall comply with the AMPM about transitioning of recipients between CRSA subcontractors and a) AHCCCS health plans or b) ALTCS program contractors upon discharge from a CRS clinic and/or discharge from the CRS program.

CRSA or its subcontractors shall coordinate a recipient's discharge from a hospital. CRSA shall advise the recipient's health plan/program contractor of the discharge and ensure coordination of the services with the health plan/program contractor.

CRSA, or its subcontractor, shall notify the recipient's health plan/program contractor to begin the coordination during the transition of care for the recipient, 30 days prior to termination of CRS eligibility, or as soon as known if less than 30 days, as required in the *AMPM*, and the ACOM, *Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy*.

10. SCOPE OF SERVICES

Children's Rehabilitative Services (CRS) shall provide medically necessary CRS covered services to AHCCCS members, including emergency services related to CRS conditions, when the provider that furnishes the service has an agreement with CRS. For emergency services rendered outside the CRS network, CRSA shall coordinate services with the CRS recipient's acute or long-term care health plan. A complete description of AHCCCS covered services can be found in the AHCCCS Medical Policy Manual (*AMPM*). Not all AHCCCS covered services are covered by CRS. CRS covered services are described in the Arizona Department of Health

Services/Children's Rehabilitative Services Rules R9-7 Article 4 and in the *CRS Contractors Policy and Procedure Manual (CPPM).*

CRSA and its subcontractors shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. CRSA or its subcontractors shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the recipient [42 CFR 438.210(a)(1), (3)(i), and (4)] unless it is outside the scope of CRSA covered services. CRSA must notify the AHCCCS Health Plan or ALTCS Program Contractor as described in Attachment H(1): Enrollee Grievance System Standard and Policy. CRSA or its subcontractors may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

CRSA and its subcontractors shall ensure that providers are not restricted or inhibited in any way from communicating freely with recipients regarding the recipients' health care, medical needs and treatment options even if the medical services are not covered by CRS. CRS shall allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the recipient to obtain one outside the network, at no cost to the recipient [42 CFR 438.206(b)(3)].

CRSA must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide, reimburse for, or provide coverage of a covered counseling or referral service. Notification must be submitted prior to entering into a contract with AHCCCS or whenever it adopts the policy during the term of the contract. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to CRS recipients during their initial appointment; and must be provided to CRS recipients at least 30 days prior to the effective date of the policy.

Per the Balanced Budget Act of 1997, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency and post stabilization services except where otherwise noted in the contract. CRS must cover and pay for post-stabilization care services without authorization, when the provider that furnishes the service has a contract with CRS, for the following situations:

1. Post-stabilization care services that were pre-authorized by CRS;
2. Post-stabilization care services that were not pre-approved by CRS because CRS did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval; or,
3. CRS' representative and the treating physician cannot reach agreement concerning the recipient's care and a CRS physician is not available for consultation. In this situation, CRS must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the recipient until a contracted physician is reached or one of the criteria in CFR 422.113(c)(3) is met.

Pursuant to CFR 422.113(c)(3), CRS' financial responsibility for post-stabilization care services that have not been pre-approved ends when:

1. A contracted physician with privileges at the treating hospital assumes responsibility for the recipient's care;
2. A contracted physician assumes responsibility for the recipient's care through transfer;
3. A representative of CRS and the treating physician reach an agreement concerning the recipient's care; or,
4. The recipient is discharged.

11. RESERVED

12. RESERVED

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS internet website, located at www.azahcccs.gov. CRSA is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS rules (Arizona Administrative Code), Statutes and other resources are also available to all interested parties through the AHCCCS website. Upon adoption by AHCCCS, updates will be made available to the CRSA. The CRSA shall be responsible for implementing these requirements and maintaining current copies of updates.

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSBC)

Pursuant to an Intergovernmental Agreement with the Department of Education, and a contract with a Third Party Administrator, AHCCCS pays participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the recipient's Individual Education Plan (IEP) as medically necessary for the child to obtain a public school education.

MSBC services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSBC approved alternative setting. Currently, services include audiology, therapies (OT, PT and speech/language); behavioral health evaluation and counseling; nursing and attendant care; and specialized transportation. The Contractor's evaluations and determinations, about whether services are medically necessary, should be made independent of the fact that the child is receiving MSBC services.

15. RESERVED

16. STAFF REQUIREMENTS AND SUPPORT SERVICES

CRSA shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, CRSA shall not employ or contract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. [42 CFR 438.610(a) and (b)]

CRSA is responsible for maintaining a significant local (within the State of Arizona) presence. This presence includes staff designated below with an asterisk (*). CRSA must obtain approval from AHCCCS prior to moving functions outside the State of Arizona. Such a request for approval must be submitted to the Division of Health Care Management at least 60 days prior to the proposed change in operations and must include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance. The CRSA shall be responsible for any additional costs associated with on-site audits or other oversight activities of required functions located outside of the State of Arizona. At the beginning of each contract year the CRSA must provide, to the Division of Health Care Management, a listing of all functions and their locations.

The CRSA must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The CRSA's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements, including the requirement for providing culturally competent services. If CRSA does not achieve the desired outcomes or maintain compliance with contractual obligations, additional

monitoring and regulatory action may be employed by AHCCCS, up to and including actions specified in Section D, Paragraph 72, Sanctions, of the Contract.

CRSA shall inform AHCCCS, Division of Health Care Management, in writing within seven days, when an employee leaves one of the Key Staff positions listed below (this requirement does not apply to Additional Required Staff, also listed below). The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place. At a minimum, the following staff is required:

At a minimum, the following staff is required:

Key Staff

a. ***Administrator/CEO/COO*** or designee must be available, full time, to fulfill the responsibilities of the position and to oversee the entire operation of the Contractor. The Administrator shall devote sufficient time to the Contractor's operations to ensure adherence to program requirements and timely responses to AHCCCS Administration.
b. ***Medical Director/CMO*** who shall be an Arizona-licensed physician. The Medical Director shall be actively involved in all-major clinical programs and QM and MM components of the Contractor. The Medical Director shall devote sufficient time to the Contractor to ensure timely medical decisions, including after-hours consultation as needed.
c. ***Chief Financial Officer/CFO*** who is available, full time, to fulfill the responsibilities of the position and to oversee the budget and accounting systems implemented by the Contractor.
d. ***Pharmacy Director/Coordinator*** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Plan.
e. ***Compliance Officer*** who will implement and oversee the Contractor's compliance program. The compliance officer shall be an on-site management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of Program Integrity. See Section D, Paragraph 62, Corporate Compliance
f. ***Grievance Manager*** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes.
g. ***Business Continuity Planning Coordinator*** as noted in the ACOM *Business Continuity and Recovery Plan Policy*
h. ***Contract Compliance Officer*** who will serve as the primary point-of-contact for all Contractor operational issues.
   The primary functions of the Contract Compliance Officer are:
   - Coordinate the tracking and submission of all contract deliverables
   - Field and coordinate responses to AHCCCS inquiries
   - Coordinate the preparation and execution of contract requirements such as OFRS, random and periodic audits and ad hoc visits
i. ***Quality Management Coordinator*** who is an Arizona-licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ). The QM Coordinator must have experience in quality management and quality improvement.
   The primary functions of the Quality Management Coordinator position are:
   - Ensure individual and systemic quality of care
   - Integrate quality throughout the organization
   - Implement process improvement
   - Resolve, track and trend quality of care grievances
   - Ensure a credentialed provider network

j. ***Performance/Quality Improvement Coordinator*** The Performance/Quality Improvement Coordinator will have a minimum qualification as a Certified Professional in Healthcare Quality (CPHQ) or comparable education and experience in data and outcomes measurement.
The primary functions of the Performance/Quality Improvement Coordinator are:
- Focus organizational efforts on improving clinical quality performance measures
- Develop and implement performance improvement projects
- Utilize data to develop intervention strategies to improve outcomes
- Report quality improvement/performance outcomes

k. ****Medical Management Coordinator*** who is an Arizona licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determination.
The primary functions of the Medical Management Coordinator are:
- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria.
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted.
- Develop, implement and monitor the provision of care coordination, disease management and case management functions.
- Monitor, analyze and implement appropriate interventioins based on utilization data, including identifying and correcting over or under utilization of services.

l. ***Member Services Manager*** who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times.

m. ****Provider Services Manager*** who shall coordinate communications between the Contractor, its subcontractors, IHS and tribally-operated health programs under P.L. 93-638 (Indian Self-Determination and Education Assistance Act); provide assistance to providers in resolving problems; respond to provider inquiries; educate providers about participation in the AHCCCS program and maintain a sufficient provider network.

n. ***Claims Administrator***
The primary functions of the Claims Administrator are:
- Develop and implement claims processing systems capable of paying claims in accordance with state and federal requirements
- Develop processes for cost avoidance
- Ensure minimization of claims recoupments
- Meet claims processing timelines
- Meet AHCCCS encounter reporting requirements

Additional Required Staff

o. ***Prior Authorization staff*** to authorize health care 24 hours per day, 7 days per week. This staff shall include an Arizona-licensed nurse, physician or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician, or physician's assistant.

p. ****Concurrent Review staff*** to conduct inpatient concurrent review. This staff shall consist of an Arizona-licensed nurse, physician, or physician's assistant. The staff will work under the direction of an Arizona-licensed nurse.

q. ****Clerical and Support staff*** to ensure appropriate functioning of the Contractor's operation.

r. ***Member Services staff*** There shall be sufficient Member Service staff to enable members to receive prompt resolution of their inquiries/problems.

s. ****Provider Services staff*** There shall be sufficient Provider Services staff to enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management, for more information).

t. ***Claims Processing staff*** There shall be sufficient, appropriately trained, Claim Processing staff to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
u. ***Encounter Processing staff*** There shall be sufficient, appropriately trained, Encounter Processing staff to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.

By August 31st, prior to each contract year, CRSA shall submit to AHCCCS, Division of Health Care Management the following:

1). CRSA's organizational chart that includes names of staff and position titles;
2). A description of staff member's functions and time allocated to overseeing CRSA operations; and,
3). A crosswalk of CRSA staff members and AHCCCS required staff positions

Staff Training and Meeting Attendance

CRSA shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill the requirements of the position. CRSA must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals; Contract requirements and State and Federal requirements specific to individual job functions. CRSA shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

CRSA shall establish minimum staffing requirements for subcontractors. CRSA shall include these staffing requirements in contract.

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. All meetings shall be considered mandatory unless otherwise indicated.

17. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

CRSA shall develop, maintain and distribute written policies, procedures and job descriptions for each functional area of its program, consistent in format and style. CRSA shall ensure that each subcontractor is issued a copy of the policies. CRSA shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. CRSA shall review all policies and procedures at least annually to ensure that CRSA's written policies reflect current practices. Reviewed policies shall be dated and signed by the appropriate administrative staff. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the CRSA Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

Based on provider or member feedback, if AHCCCS deems a Contractor policy or process to be inefficient and/or place unnecessary burden on the members or providers, the Contractor will be required to work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS.

CRSA shall provide AHCCCS with a copy of the CRSA policy manual. Copies of final policies shall be submitted to AHCCCS at least ten (10) working days prior to implementation. AHCCCS shall receive updates on an as-revised basis. AHCCCS shall distribute CRS policies to the health plans/program contractors when appropriate.

18. RECIPIENT INFORMATION

All informational materials shall be reviewed for accuracy and approved by CRSA prior to distribution to recipients.

All materials shall be translated when CRSA is aware that a language is spoken by 3,000 or 10%, whichever is less, of CRSA's recipients who also have Limited English Proficiency (LEP).

All vital materials shall be translated when CRSA is aware that a language is spoken by 1,000 or 5%, whichever is less, of CRSA's recipients who also have LEP [42 CFR 438.10(c)(3)]. Vital materials must include, at a minimum, Notices of Action, vital information from the recipient handbooks and consent forms.

All written notices informing recipients of their right to interpretation and translation services in a language shall be translated when CRSA is aware that 1,000 or 5%, whichever is less, of CRSA's recipients speak that language and have LEP.

Oral interpretation services must be available and free of charge to all recipients regardless of the prevalence of the language. CRSA, and its subcontractors, must notify all recipients of their right to access oral interpretation services and how to access them [42 CFR 438.10(c)(4) and 438.10(c)(5)(i) and (ii)]. Refer to the ACOM, *CRS Recipient Information Policy.*

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM, *CRS Recipient Information Policy*. Regardless of the format chosen, the CRS recipient information must be printed in a type, style and size, which can easily be read by recipients with varying degrees of visual impairment. CRSA or its subcontractors must notify its recipients that alternative formats are available and how to access them [42 CFR 438.10(d)(1)(i) and (ii), 42 CFR 438.10(d)(2)].

CRSA or its subcontractors shall produce and provide the following printed information to each recipient or family within 10 days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]:

1. A recipient handbook, which, at a minimum, shall include the items, listed in the ACOM, *CRS Recipient Information Policy*.

   CRSA or its subcontractors shall review and update the Recipient Handbook at least once a year. The handbook must be submitted to AHCCCS, DHCM for approval by August 15th of each contract year, or within 45 days of signing the Contract Renewal, whichever comes later.

2. A description of CRSA or its subcontractor's provider network, which at a minimum, includes those items listed in the ACOM, *CRS Recipient Information Policy.*

CRSA or its subcontractors must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each recipient who received their primary care from, or is seen on a regular basis by, the terminated provider. Affected members must be informed of any other changes in the network 30 days prior to the implementation date of the change. [42 CFR 438.10(f)(5)]. Provider notices do not require prior approval.

A material change in CRSA policy or process requires 30 days advance notice to affected providers and recipients. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the recipients, providers, or AHCCCS programs, or may significantly impact the delivery of services provided by CRSA. CRSA shall require its subcontractors to submit the recipient notices to CRSA for review and approval. Affected recipients must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4)]. When there are program changes, notification shall be provided to the affected recipients at least 30 days before implementation.

CRSA or its subcontractors will, on an annual basis, inform all CRS recipients of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)]:

a. An updated recipient handbook at no cost to the recipient; and,
b. The network description as described in the ACOM *CRS Recipient Information Policy*.

This information may be sent in a separate written communication or included with other written information such as in a recipient newsletter.

19. SURVEYS

Unless waived by AHCCCS, CRSA shall perform its own annual general or focused recipient survey. CRSA shall submit the proposed recipient survey tool, sample and distribution methodology and a timeline to AHCCCS for review and approval no later than 90 days prior to the intended start of the survey. CRSA shall include questions related to appointment waiting time. AHCCCS may require inclusion of certain questions. The results and the analysis of the results shall be submitted to the Division of Health Care Management within 45 days of the completion of the survey. CRSA shall ensure that subcontractors utilize recipient survey findings to improve care for Title XIX and Title XXI members. The results of these surveys are public information and must be available to all interested parties upon request.

AHCCCS may choose to conduct surveys of a representative sample of CRSA's membership and providers. AHCCCS will consider suggestions from CRSA for questions to be included in each survey. The draft reports from the survey will be shared with CRSA prior to finalization. The results of these surveys will become public information and available to all interested parties upon request. CRSA will be responsible for reimbursing AHCCCS the cost of the survey.

20. CULTURAL COMPETENCY

CRSA shall have a Cultural Competency Plan that meets the requirements of the ACOM, *Cultural Competency Policy*. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the DHCM no later than 45 days after the start of each contract year. This plan should address all services and settings. [42 CFR 438.206(c)(2)]

21. MEDICAL RECORDS

The recipient's medical record is the property of the provider who generates the record. Each recipient is entitled to one copy of his or her medical record free of charge. CRSA shall have written policies and procedures to ensure the confidentiality of all medical records.

CRSA shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

CRSA shall have written standards for documentation on the medical record for legibility, accuracy and plan of care which comply with the *AMPM*. AHCCCS or its designee may inspect such records at any time during regular business hours at the offices of CRSA, subcontractors, at hospitals or other service providers.

CRSA shall have written plans for training and for evaluation of CRSA subcontractors' compliance with CRSA's medical record standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

AHCCCS is not required to obtain written approval from a recipient before requesting the recipient's medical record. CRSA may obtain a copy of a recipient's medical records without written approval of the recipient if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all recipients' medical records whether electronic or paper within 20 working days of receipt of request.

Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed in accordance with ARS §36-664(I).

22. ADVANCE DIRECTIVES

In accordance with 42 CFR 422.128, CRSA shall maintain policies and procedures addressing advanced directives for adult CRS recipients that specify items a. through c. below. For the purposes of the advanced directives, an adult CRS recipient is an individual who is eighteen (18) years of age or older.

a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care, must comply with Federal and State law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:

    1) Maintaining written policies that address the rights of adult CRS recipients to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If an agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.);
    2) Provide written information to adult CRS recipients regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)];
    3) Documenting in the CRS recipient's medical record whether or not the adult CRS recipient has been provided the information and whether an advance directive has been executed.
    4) Not discriminating against a CRS recipient because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
    5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by CRS recipients to whom they are assigned to provide services.

b. CRSA shall ensure providers, which have agreements with the entities described in paragraph a. above, comply with the requirements of subparagraphs a. 2) through 5) above. CRSA shall also encourage health care providers specified in subparagraph a. to provide a copy of the CRS recipient's executed advanced directive, or documentation of refusal, to the acute care PCP for inclusion in the member's medical record.

c. CRSA shall ensure that adult CRS recipients are provided written information describing the following:

    1) A CRS recipient's rights under State law, including a description of the applicable State law;

2) Policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
3) The CRS recipient's right to file complaints directly with AHCCCS; and,
4) Changes to State law as soon as possible, but no later than 90 days after the effective date of the change. [42 CFR 438.6(i)(4)]

23. QUALITY MANAGEMENT (QM)

Quality Management (QM):
CRSA or its subcontractors shall provide quality medical care and services to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement processes. CRSA shall execute processes to assess, plan, implement and evaluate quality management and performance improvement activities, as specified in the AMPM, that include at least the following [42 CFR 438.240(a)(1) and (e)(2)]:

The Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AMPM and this Paragraph.

A. Quality Management Program:
The Conractor shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPM Capter 900 and the following:

1. A written Quality Assessment and Performance Improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and Quarterly QA/PI reports that address its strategies for performance improvement and conducting the quality management activites.
2. QM/PI Program monitoring and evaluation activites that includes Peer Review and Quality Management Committees chaired by the Contractor's Chief Medical Officer.
3. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
4. Member rights and responsibilities.
5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's Medical Director [42 CFR 438.214]. The Contractor should refer to Section D, Paragraph 25, Administrative Performance Standards, and Attachement F, Periodic Report Requirements, for reporting requirements. The process:
    a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the Contractor;
    b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
    c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
    a. Acknowledgement letter to the originator of the concern;
    b. Documentation of all steps utilized during the investigation and resolution process;
    c. Follow-up with the member to assist in ensuring immediate health care needs are met;
    d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;

e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
f. Analysis of the effectiveness of the interventions taken.

7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
9. Performance improvement programs including performance measures and performance improvement projects.

B. Performance Improvement

The Contractor's quality management program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical care and non-clinical care that are expected to have a favorable effect on health outcomes and member satisfaction. The Contractor must [42 CFR 438.240(b)(2) and (c)]:

1. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS;
2. Submit to the State data specified by the State, that enables the State to measure the Contractor's performance; or
3. Perform a combination of the activities.

Performance Standards [42 CFR 438.240(a)(2), (b)(2) and (c)]*:* All Performance Standards described below apply to all recipients. CRSA must meet AHCCCS stated Minimum Performance Standards. However, it is equally important that CRSA continually improve its performance indicator measure outcomes from year to year. CRSA shall strive to meet the goal established by AHCCCS.

Any statistically significant drop in CRSA's performance level for any measure must be explained by the CRSA in its annual quality management program evaluation. If CRSA has a significant drop in any measure without a justifiable explanation, it will be required to submit a corrective action plan and may be subject to sanctions.

AHCCCS has established two levels of performance:

Minimum Performance Standard – A Minimum Performance Standard is the minimally expected level of performance by CRSA. If CRSA does not achieve this standard, or the rate for any indicator declines to a level below the AHCCCS Minimum Performance Standard, CRSA will be required to submit a corrective action plan and may be subject to sanctions.

Goal – The Goal is the ultimate benchmark to be achieved. If CRSA has already achieved or exceeded the Minimum Performance Standard for any performance measure, CRSA must strive to meet the goal for that measure. If CRSA has achieved the Goal, it is expected to maintain this level of performance in future years.

CRSA must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions on CRSA if it does not meet the Minimum Performance Standard and does not show statistically significant improvement in any performance measure rate and/or require CRSA to demonstrate that it is allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan from CRSA if a statistically significant decrease in its rate is shown, even if it meets or exceeds the Minimum Performance Standard.

The corrective action plan must be received by AHCCCS within 30 days of receipt of notification from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up on-site reviews to verify compliance with a corrective action plan.

The following table identifies the Minimum Performance Standards and Goals for each Measure:

CRS Performance Measures

Performance Measure	Minimum Performance Standard	Goal
Preliminary Determination of Medical Eligibility	75%	90%
Timeliness of Initial Evaluation	75%	90%
First Appointment with CRS Specialty Provider	75%	90%

The Performance Measures are defined as follows:

Preliminary Determination of Medical Eligibility – The percent of AHCCCS members for whom:

1) A preliminary determination of medical eligibility was made and who were notified in writing of their scheduled initial clinic appointment date (to determine medical eligibility) within 14 calendar days of a complete CRS Referral Form* received by a CRS subcontractor;
2) A preliminary determination of medical eligibility could not be made because the CRS Referral Form received was incomplete and who were notified in writing within 14 calendar days of receipt of the Referral Form of the additional information that must be submitted in order for the CRS subcontractor to make a preliminary determination of medical eligibility; and,
3) A determination was made that the member was <u>not</u> medically eligible and who were notified in writing that their eligibility was denied within 14 calendar days of a complete CRS Referral Form* received by a CRS subcontractor.

* A complete CRS Referral Form is one that includes information in all the required fields to be submitted on the form, as specified in the CPPM, Chapter 4.0. .

Denominator: All AHCCCS-enrolled children (age up to 21 years) referred to CRS during the measurement period.

Numerators:

1) All children in the denominator whose written notice of preliminary determination of medical eligibility (with a scheduled clinic appointment date) was mailed within 14 calendar days of a complete CRS Referral Form received by a CRS subcontractor.
2) All children in the denominator whose written notice of additional information needed to make a preliminary determination of medical eligibility was mailed within 14 calendar days of a CRS Referral Form received by a CRS subontractor.
3) All children in the denominator whose written notice of denial for CRS eligibility was mailed within 14 calendar days of a complete CRS Referral Form received by a CRS subontractor.

Measurement Period: October 1, 2008, through September 30, 2009

Data Collection and Validation Process: CRSA will collect denominator and numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the

information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). At a minimum, CRSA will provide each member's AHCCCS ID number (unless the individual was determined not medically eligible for CRS services), name, date of birth, the date the CRS Referral Form was received by the subcontractor, whether the Form was complete or incomplete, the date that CRS sent the first written notice regarding eligibility determination, and whether the individual was or was not eligible.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

Timeliness of Initial Evaluation – The percent of AHCCCS-enrolled members who were scheduled for an initial clinic appointment (evaluation) within 30 calendar days after a notice of preliminary determination of medical eligibility was mailed to the member or member's parent.

Denominator: All AHCCCS-enrolled children who were determined eligible for and enrolled in CRS during the measurement period.

Numerator: All children in the denominator whose initial medical evaluation appointment was scheduled for a date that was no more than 30 days after a notice of preliminary determination of medical eligibility was mailed by the CRS Regional Contractor.

Measurement Period: October 1, 2008, through September 30, 2009.
Data Collection and Validation Process: CRSA will collect denominator and numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). At a minimum, CRSA will provide each member's AHCCCS ID number, name, date of birth, the date for which the initial medical evaluation appointment was first scheduled following preliminary determination of medical eligibility and the date that the notice of preliminary determination of medical eligibility was mailed to the member or member's parent.

AHCCCS will identify a statistically significant random sample of recipients who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

First Appointment with CRS Specialty Provider – The number of AHCCCS members who are enrolled in CRS and are scheduled for their first specialty clinic visit within 45 calendar days of the CRS Regional Contractor making a positive determination of medical eligibility.

Denominator: All AHCCCS children enrolled in CRS during the measurement period.

Numerator: All children in the denominator who are scheduled for their first specialty clinic visit within 45 days of the CRS Regional Contractor making a positive determination of medical eligibility (enrollment date).

Measurement Period: October 1, 2008, through September 30, 2009

Data Collection and Validation Process: CRSA will collect denominator and numerator data from CRS clinic systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). At a minimum, CRSA will provide each member's AHCCCS ID number, name, date of birth,

the date for which the specialty clinic appointment was first scheduled following determination of medical eligibility and enrollment in CRS. AHCCCS may, as an alternate method of collecting data, identify specialty visits for members in the denominator from its encounter data.
AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request CRSA to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

Data Requirements for Performance Measurement and Improvement

When requested, the Contractor must submit data for standardized Performance Measures and/or Performance Improvement Projects as required by AHCCCS within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data, using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or Performance Improvement Projects must be returned by the Contractor in the format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

Quality Improvement:

CRSA shall have an ongoing quality assessment and performance improvement programs for the services it furnishes to recipients. [42 CFR 438.240(a)(1)] Basic elements of the CRSA quality assessment and performance improvement programs, at a minimum, shall comply with the following requirements:

A. Quality Assessment Program:

1. The program shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.
2. CRSA must [42 CFR 438.240(b)(2) and (c)]: :
   a. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS,
   b. Submit to the State, data specified by the State, that enables the State to measure CRSA's performance; or,
   c. Perform a combination of the activities.
3. CRSA must have in effect mechanisms to detect both underutilization and over utilization of services [42 CFR 438.240(b)(3)].
4. CRSA must have in effect mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs [42 CFR 438.240(b)(4)].
5. CRSA must have in place a process for internal monitoring of Performance Measure rates, using standard methodology established or adopted by AHCCCS, for each required Performance Measure. CRSA's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its administration. It also will report this Performance Measure data to AHCCCSA.

B. Performance Improvement Program:

CRSA shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following [42 CFR 438.240(a)(1) and (d)(1)]:

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions; and,
4. Planning and initiation of activities for increasing or sustaining improvement.

CRSA shall report the status and results of each project to the AHCCCSA as requested. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. [42 CFR 438.240(d)(2)]

CRSA must submit the self selected proposed PIP methodology to AHCCCSA for review and approve by December 15th annually.

CRSA will conduct the following Performance Improvement Project (PIP):

Improving Pediatric to Adult Transition Services – This PIP will measure and implement activities to improve transition planning and services beginning at age 14 for AHCCCS members who are receiving services from CRS and will transition back to their Health Plans by age 21.

The AHCCCS-approved methodology for this PIP is included as Attachment F.

CRSA must develop and submit a self-selected proposal to AHCCCSA for a new PIP to be implemented in CYE 2009.

CRSA shall report the status and results of each project to AHCCCSA as requested [42 CFR 438.240(d)(2)]. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year [42 CFR 438.240(d)(2)].

24. MEDICAL MANAGEMENT (MM)

Medical Management (MM*)*
CRSA shall execute processes to assess, plan, implement and evaluate utilization management activities, as specified in the *AMPM,* that include at least the following:

1. Pharmacy Management including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee;
2. Prior authorization and Referral Management;
   For the processing of requests for initial and continuing authorizations of services CRSA shall:
   a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions [42 CFR 438.210(b)(2)];
   b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
   c. Monitor and ensure that all enrollees with special health care needs have direct access to care;
3. Develop and/or adoption of practice guidelines [42 CFR 438.236(b)] that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
   b. Consider the needs of CRSA members;
   c. Are adopted in consultation with contracting health care professionals;
   d. Are reviewed and updated periodically as appropriate;
   e. Are disseminated by CRSA to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and,

f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].

4. Concurrent review;
   a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply;
   b. Discharge planning
5. Continuity and coordination of care;
6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438.240(b)(3)];
7. Evaluation of new medical technologies, and new uses of existing technologies;
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee; and
9. Quarterly Utilization Management Report (details in the *AMPM*)
10. Within the first two years of the contract term, the CRSA must review all prior authorization requirements for services, items or medications and submit a report to AHCCCS providing the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

CRSA shall have a process to report MM data and management activities through a MM Committee. CRSA's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. CRSA shall have in effect mechanisms to assess the quality and appropriateness of care furnished to recipients with special health care needs. [42 CFR 438.240(b)(4)]

CRSA will assess, monitor and report quarterly through the MM Committee medical decisions to assure compliance with timeliness, language and Notice of Action content, and that the decisions comply with all Contractor coverage criteria.

CRSA shall maintain a written MM plan that addresses its plan for monitoring MM activities described in this section. The plan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in ATTACHMENT F.

25. ADMINISTRATIVE PERFORMANCE STANDARDS

This paragraph contains requirements for CRSA's Member Services, Provider Services and Claims Services telephonic performance; as well as the measurement of credentialing timeliness. All reported data is subject to validation through periodic audit and/or Operational and Financial Review.

Telephone Standards

The maximum allowable speed of answer (SOA) is 45 seconds. The SOA is defined as the on line wait time in seconds that the member/provider waits from the moment the call is connected in the Contractor's phone switch until the call is picked up by a contractor representative or Interactive Voice Recognition System (IVR). If the Contractor has IVR capabilities, callers must be given the choice of completing their call by IVR or by contractor representative.

The Contractor shall meet the following standards for its member services and centralized provider telephone line statistics. All calls to the line shall be included in the measure.

a. The Monthly Average Abandonment Rate shall be 5% or less;
b. First Contact Call Resolution shall be 70% or better; and
c. The Monthly Average Service Level shall be 75% or better.

The Monthly Average Abandonment Rate (AR) is:

$$\frac{\text{Number of calls abandoned in a 24-hour period}}{}$$

Total number of calls received in a 24-hour period

The ARs are then summed and divided by the number of days in the reporting period.

First Contact Call Resolution Rate (FCCR) is:

Number of calls received in 24-hour period for which no follow up communication or internal phone transfer is needed, divided by Total number of calls received in 24-hour period

The daily FCCRs are then summed and divided by the number of days in the reporting period.

The Monthly Average Service Level (MASL) is:

Calls answered within 45 seconds for the month reported
Total of month's answered calls + month's abandoned calls + (if available) month's calls receiving a busy signal

Note: Do **not** use average daily service levels divided by the days in the reporting period.

On a monthly basis the measures are to be reported for both the Member Services and Provider telephone lines. For each of the Administrative Measures a. through c., the Contractor shall also report the number of days in the reporting period that the standard was not met. CRSA shall include in the report the instances of down time for the centralized telephone lines, the dates of occurrence and the length of time they were out of service. The reports should be sent to CRSA's assigned Operations and Compliance Officer in the Acute Care Operations Unit of the Division of Health Care Management. The deadline for submission of the reports is the 15th day of the month following the reporting period (or the first business day following the 15th). Back up documentation for the report, to the level of measured segments in the 24-hour period, shall be retained for a rolling 12-month period. AHCCCS will review the performance measure calculation procedures and source data for this report.

Credentialing Timeliness

CRSA is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor will divide the number of complete applications processed (approved/denied) during the time period by the number of complete applications that were received during the time period, as follows:

Complete applications processed
Complete applications received

The standards for processing are listed by category below:

Type of Credentialing	14 days	90 days	120 days	180 days
Provisional	100%			
Initial		90%	95%	100%

CRSA will also report the following information with regard to all credentialing applications on a quarterly basis, as specified in Attachment F, Periodic Report Requirements:

1. Number of applications received
2. Number of completed applications received (separated by type: provisional, initial)
3. Number of completed provisional credentialing applications approved
4. Number of completed provisional credentialing applications denied

5. Number of initial credentialing applications approved
6. Number of initial credentialing applications denied
7. Number of initial (include provisional in this number) applications processed within 90, 120, 180 days

26. GRIEVANCE SYSTEM

CRSA shall have in place a written grievance system process for subcontractors, CRS recipients, providers and non-contracted providers, which define their rights regarding disputed matters with the CRSA. CRSA's grievance system for recipients includes a grievance process (the procedures for addressing recipient grievances), an appeals process and access to the State's fair hearing process. CRSA shall provide the appropriate personnel to establish, implement, and maintain the necessary functions related to the grievance systems process. Refer to Attachments H(1) and H(2) for *CRS Recipient Grievance System and Provider Grievance System Standards and Policy, respectively*.

CRSA may delegate the grievance system process to subcontractors, however, the CRSA must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. CRSA shall remain responsible for compliance with all requirements. CRSA shall also ensure that it timely provides written information to both CRS recipients and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a State fair hearing, a method for obtaining a state fair hearing, the rules that govern representation at the hearing, the right to file grievance, appeals, and claim dispute the requirements and timeframes for filing grievance, appeals and claim dispute, the availability of assistance in the filing process, the toll-free numbers that the CRS recipient can use to file a grievance or appeal by phone, that benefits will continue when requested by the CRS recipient in an appeal or State fair hearing request concerning certain action which are timely filed, that the CRS recipient may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the CRS recipient, and that a provider may file an appeal on behalf of an CRS recipient with the CRS recipient's written consent. Information to CRS recipients must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 18, Recipient Information, and Section D, Paragraph 20, Cultural Competency.

CRSA shall be responsible to provide the necessary professional, paraprofessional and clerical services for the representation of CRSA in all issues relating to the grievance system and any other matters arising under this contract which rise to the level of administrative hearing or a judicial proceeding. Unless there is an agreement with the State in advance, CRSA or its subcontractors shall be responsible for all attorney fees and costs awarded in a judicial proceeding.

CRSA will provide reports on the Grievance System as required in the Grievance Reporting Guide.

27. NETWORK DEVELOPMENT

CRSA shall develop and maintain a provider network that is supported by written agreements, which is sufficient to provide all CRS covered services to CRS enrolled AHCCCS members [42 CFR 438. 206(b)(1)]. CRSA shall ensure covered services are provided promptly and are accessible in terms of location and hours of operation [42 CFR 438.206(c)(2)(ii)]. There shall be sufficient professional and paramedical personnel for the provision of CRS services.

If the network is unable to provide medically necessary services required under contract, CRSA or its subcontractors shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted [42 CFR 438.206(b)(4)]. CRSA shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b) (5)]

CRSA or its subcontractors shall not discriminate with respect to participation in the CRS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)]. In addition, CRSA or its subcontractors must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit limiting provider participation to the extent necessary to meet the needs of CRS recipients. This provision also does not interfere with measures established by CRSA or its subcontractor to control costs consistent with its responsibilities under this contract nor does it preclude CRSA from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If CRSA or its subcontractor decline to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision [42 CFR 438.12(a)(1)]. CRSA or its subcontractors may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

Provider Network Development and Management Plan: CRSA or its subcontractors shall develop and maintain a provider network development and management plan, which ensures that the provision of CRSA covered services will occur as stated above [42 CFR 438.207(b)]. This plan shall be updated annually and submitted to AHCCCS, DHCM, 45 days from the start of each contract year. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of CRSA' provider network. CRSA shall also submit as needed an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population. [42 CFR 438.207(c)] The plan shall also contain a description of the Contractor's criteria used to determine the numbers and kinds of specialists included in the network. The plan shall identify the current status of the CRSA's network, and project future needs based upon, at a minimum, recipient growth; the number and types (in terms of training, experience and specialization) of providers that exist in CRS' service area, as well as the number of physicians who have privileges with and practice in hospitals; the expected utilization of services, given the characteristics of its population and its health care needs; the numbers of providers not accepting new Medicaid patients; and access of its recipients to specialty services as compared to the general population of the community. [42 CFR 438.206(b)(1)] The plan, at a minimum, shall also include the following:

a. A network inventory of CRSA subcontractors and their providers by facility, provider type, name and specialization;
b. Current network gaps and methodology used to identify them;
c. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing;
d. Interventions to fill network gaps and barriers to those interventions;
e. Outcome measures/evaluation of interventions;
f. Ongoing activities for network development;
g. Coordination between internal departments;
h. Coordination with outside organizations; and,
i. A description of network designed by subcontractors
j. The methodology (ies) the Contractor uses to collect and analyze provider feedback about the network designs and implementation. When specific provider issues are identified, the protocols for handling them.

Provider-CRS Recipient Communication: CRSA shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a CRS recipient who is his or her patient, for:

a. The CRS recipient's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)];
b. Any information the CRS recipient needs in order to decide among all relevant treatment options [42 CFR 438.102(a)(1)(ii)];
c. The risks, benefits, and consequences of treatment or non-treatment; and [42 CFR 438.102(a)(1)(iii)],
d. The CRS recipient's right to participate in decisions regarding his or her care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.102 (a)(1)(iv)].

28. RESERVED

29. NETWORK MANAGEMENT

CRSA shall have policies and procedures in place that pertain to all service specifications described in the *CRSA' Children's Rehabilitative Services Policy and Procedure Manual*. In addition, CRSA shall have policies specifying how CRSA will [42 CFR438.214(a)]:

a. Communicate with the CRS network regarding contractual and/or program changes and requirements;
b. Monitor and ensure network compliance with policies and rules of AHCCCS and CRSA including compliance with policies and procedures related to the grievance process and ensuring the recipient's care is not compromised during the grievance process;
c. Evaluate the quality of services delivered by the network;
d. Provide or arrange for medically necessary covered services should the CRS network become temporarily insufficient;
e. Monitor network capacity to ensure that there are sufficient providers to handle the volume and needs of CRS recipients. This includes the provision of care to CRS recipients with limited English proficiency; and,
f. Process expedited and temporary credentials;
g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling; and
h. Provide training for its providers and maintain records of such training.
i. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
j. Ensure that provider calls are acknowledged within 3 business days of receipt; resolved and the result communicated to the provider within 30 business days of receipt.

CRSA policies shall be subject to approval by AHCCCS, Division of Health Care Management, and shall be monitored through operational audits.

The Contractor is required to obtain prior approval from AHCCCS, DHCM regarding material changes to operations. A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol, etc.) that could have an impact on or reasonably be foreseen to have an impact on more than 5% of the members and/or providers. The Contractor must submit the request for approval of material change, including draft notification to affected members and providers, 60 days prior to the expected implementation of the change. The request should contain, at a minimum, information regarding the nature of the change; the reason for the change; methods of communication to be used; and the anticipated effective date. If AHCCCS does not respond to the Contractor within 30 days; the request and the notices are deemed approved. A material change in Contractor operations requires 30 days

advance written notice to affected providers and members. The requirements regarding material changes do not extend to contract negotiations between the Contractor and a provider.

The Contractor may be required to conduct meetings with providers to address issues (or to provide general information, technical assistance, etc.) related to federal and state requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by the Administration.

CRSA shall maintain and monitor a network of providers that is supported by written agreements, which is sufficient to provide adequate access to all services covered under the contract [42 CFR 438.206(b)(1)]. In establishing and maintaining the network, CRSA must consider the following [42 CFR 438.206(b)(1)]:

a. Anticipated number of CRS recipients;
b. Expected utilization of services, considering recipient characteristics and health care needs;
c. Number and types (in terms of training, experience and specialization) of providers required to provide the contracted services;
d. Network providers who are not accepting new CRS recipients; and,
e. The geographic location of providers and recipients, considering distance, travel time, the means of transportation used by CRS recipients and whether the location provides physical access for CRS recipients with disabilities.

The Contractor shall give hospitals and provider groups 90 days notice prior to a contract termination without cause. Contracts between the Contractor and single practitioners are exempt from this requirement.

All material changes in the Contractor's provider network must be approved in advance by AHCCCS, Division of Health Care Management [42 CFR 438.207(c)]. A material change to the network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. The Contractor must submit the request for approval of material change, including draft notification to affected members, 60 days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If AHCCCS does not respond within 30 days the request and the notice are deemed approved. A material change in Contractor network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

The Contractor shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network. This notification shall include (1) information about how the change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

30. RESERVED

31. RESERVED

32. RESERVED

33. APPOINTMENT STANDARDS FOR CRS RECIPIENTS

For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. CRSA and its subcontractors shall have procedures in place that ensure the following standards are met:

1. For a CRS recipient with a medically urgent need, the CRS recipient must be seen according to the needs of the member and no later than 72 hours of the request.
2. All other clinic appointments scheduled within 45 calendar days or less of referral, depending on the need of the CRS recipient's medical condition.

CRSA shall actively monitor the adequacy of its subcontractors' appointment processes and reduce the unnecessary use of alternative methods i.e., emergency room visits [42 CFR 438.206(c)(1)(i)]. CRSA shall actively monitor and ensure that a recipient's waiting time for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency.

If a health plan/program contractor is required to render any CRS covered service due to CRSA or its subcontractors' failure to meet medically necessary appointment standards, CRSA shall be financially responsible for those services as specified in the *AMPM*, Chapter 400, *Children's Rehabilitative Services Medically Necessary Appointment Policy*.

Missed appointments shall be rescheduled in a timely manner. In the event a recipient misses an appointment, CRSA shall ensure the appointment is rescheduled no later than 45 days unless medical judgment warrants an earlier appointment.

CRSA shall have written policies and procedure about educating its provider network regarding appointment time requirements. CRSA must develop a corrective action plan when appointment standards are not met. If appropriate, the corrective action plan should be developed in conjuction with subcontractor(s) [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. CRSA shall be subject to sanction for failure to address subcontractors that do not meet appointment standards. Appointment standards shall be included in the Policies and Procedure Manual. CRSA is encouraged to include the standards in the provider subcontract.

If a CRS recipient needs medically necessary non-emergency transportation, CRSA or CRSA subcontractors shall notify and coordinate with the health plan or program contractor to arrange transportation for AHCCCS members.

34. RESERVED

35. PROVIDER POLICY AND PROCEDURE MANUAL

CRSA or its subcontractors shall develop, distribute and maintain a policy and procedure manual as described below. CRSA shall ensure that each subcontractor is made aware of a website policies and procedure manual, or if requested, issued a copy of the policy and procedure manual and is encouraged to distribute a copy to any individual or group that submits claim and encounter data. CRSA shall be responsible for ensuring that all providers, whether contracted or not, meet all applicable AHCCCS requirements including the provision of covered services and billing. At a minimum, CRSA or its subcontractors' policy and procedure manual must contain information on the following:

a. Introduction to CRS, which explains CRS' organization and administrative structure
b. Provider responsibility and CRS' expectations of the provider
c. Overview of CRS' Provider Services department and function
d. Listing and description of covered and non-covered services, requirements and limitations

e. Emergency room utilization (appropriate use of the emergency room)
f. CRSA's reporting requirements for providers to report to the recipient's PCP
g. Grievance system process and procedures for providers and recipients
h. Billing and encounter submission information
i. Information about policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
j. Reimbursement, including reimbursement for dual eligibles (i.e., Medicare and Medicaid) or members with other insurance
k. Explanation of remittance advise
l. Prior authorization and notification requirements
m. Claims medical review
n. Concurrent review
o. Fraud and abuse
p. AHCCCS appointment standards
q. Coordination of services with AHCCCS health plan/program contractors
r. Information about a recipient's right to be treated with dignity and respect as specified in 42 CFR 438.100
s. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist recipients who speak a language other than English or who use sign language.
t. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable
u. Formulary information, including updates when changes occur, must be provided in advance to providers, including pharmacies. CRSA or its subcontractor is not required to send a hard copy, unless requested, of the formulary each time it is updated. A memo may be used to notify providers of update formulary on CRSA or its subcontractor's website
v. Notification that CRSA has no policies which prevent the provider from advocating on behalf of the member
w. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions
x. Eligibility verification

This information may also be contained in the provider contract.

36. PROVIDER REGISTRATION

CRSA shall ensure that each of its subcontractors register with AHCCCS as an approved service provider. A Provider Participation Agreement must be signed by each provider who is not already an AHCCCS registered provider. The original shall be forwarded to AHCCCS. This provider registration process must be completed in order for CRSA to report services a provider renders to CRS recipients. The National Provider Identifier (NPI) is required on all claim submissions and subsequent encounters (from providers who are eligible for a NPI). CRSA shall work with providers to obtain their NPI.

Except as otherwise required by law or as otherwise specified in a contract between a Contractor and a provider, the AHCCCS Administration fee-for-service provisions referenced in the AHCCCS Provider Participation Agreement located on the AHCCCS website (e.g. billing requirements, coding standards, payment rates) are in force between the provider and Contractor.

37. CRSA SUBCONTRACTS AND SUBCONTRACTOR MANAGEMENT

Arizona Department of Health Services/Children's Rehabilitative Services Administration (ADHS/CRSA) shall be responsible for the performance of all contracted requirements. CRSA may delegate responsibilities

for services and related activities under this contract, but remains ultimately responsible for compliance with the terms of this contract [42 CFR 438.230(a)].

CRSA shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c)]. No CRSA subcontract shall operate to terminate the legal responsibility of CRSA to ensure that all activities carried out by the CRSA subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by CRSA pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(L)]. See the ACOM *Contractor Claims Processing by Health Plan Subcontracted Providers* policy

The following types of Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval at least 30 days prior to the beginning date of the subcontract.

Administrative Services Subcontracts:

1. Delegated agreements that subcontract:
    a) Any function related to the management of the contract with AHCCCS. Examples include member services, provider relations, quality management, medical management (e.g., prior authorization, concurrent review, medical claims review)
    b) Claims processing, including pharmacy claims.
    c) Credentialing including those for only primary source verification
2. All Management Service Agreements
3. All Service Level Agreements with any Division or Subsidiary of a corporate parent owner

AHCCCS may, at its discretion, communicate directly with ADHS regarding the performance of a subcontractor or CRSA respectively.

CRSA shall maintain a fully executed original of all CRSA subcontracts, related to AHCCCS covered services, which shall be accessible to AHCCCS within two business days of request by AHCCCS. All requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of CRSA except as required by law. As it pertains to AHCCCS members and services, a CRSA subcontract is voidable and subject to immediate cancellation by AHCCCS in the event any CRSA subcontract referenced above is implemented without the prior written approval of AHCCCS. All CRSA subcontracts related to AHCCCS covered services shall comply with the applicable provisions of Federal and State laws, regulations and policies.

CRSA and/or the subcontractors shall not contract or subcontract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549. [42 CFR 438.610(a) and (b)] Due to security and identity protection concerns, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers. CRSA must timely submit final, signed copies of each contract which it enters into with subcontractors and Tribal subcontractors and any subsequent amendments. CRSA shall require that copies of executed contracts between a subcontractor and service provider shall be made available within five days of a request by AHCCCS. It is CRSA' responsibility to prepare and distribute to all interested parties upon request the subcontractors contract amendments resulting from federal or state legislative changes or changes in the terms of this contract and to ensure that subsequent provider subcontract amendments are completed in a timely manner.

Before entering into a subcontract which delegates CRSA duties or responsibilities to a subcontractor, CRSA must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If CRSA delegates duties or responsibilities such as utilization management or claims processing to a subcontractor, then CRSA shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor [42 CFR 438.230(b)(2)]. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate [42 CFR 438.230(b)(2)]. In order to determine adequate performance, CRSA shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by AHCCCS [42 CFR 438.230(b)(3)]. The schedule for review shall be submitted to AHCCCS, Division of Health Care Management for prior approval. CRSA shall advise AHCCCS in writing within five working days any subcontractors' noncompliance, resulting in a corrective action, including the amount and duration of the sanction, to ensure subsequent compliance. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)(4)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion [42 CFR 438.230(b)(3)].

The Contractor must submit the Annual Subcontractor Assignment and Evaluation Report (within 90 days from the start of the contract year) detailing any Contractor duties or responsibilities that have been subcontracted as described under administrative subcontracts previously in this section. If the Contractor does not assign any duties under the subcontract types listed in the paragraph above, a statement to this effect must be submitted in lieu of the Annual Subcontractor Assignment and Evaluation Report. The Annual Subcontractor Assignment and Evaluation Report will include the following:

- Subcontractor's name
- Delegated duties and responsibilities
- Most recent review date of the duties and responsibilities of the subcontractor
- A comprehensive evaluation of the performance (operational and financial) of the subcontractor
- Next scheduled review date
- Identified areas of deficiency
- Contractor's corrective action plan

CRSA shall promptly inform AHCCCS, Division of Health Care Management, in writing if a subcontractor is in significant non-compliance that would affect its abilities to perform the duties and responsibilities of the subcontract.

CRSA shall not include covenant-not-to-compete requirements in its subcontracts. Specifically, CRSA shall not contract with a provider and require that the provider not provide services for any other AHCCCS contractor. In addition, except for cost sharing requirements, CRSA shall not enter into subcontracts that contain compensation terms that discourage provider from serving any specific eligibility category.

Each CRSA subcontract must contain verbatim all the provisions of Attachment A, Minimum Subcontract Provisions. In addition, each CRSA contract must contain the following [42 CFR 438.206(b)(1)]:

a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
b. Identification of the name and address of the subcontractor.
c. Identification of the population, to include patient capacity, to be covered by the subcontractor.

d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
e. The term of the contract including beginning and ending dates, methods of extension, termination and renegotiation.
f. The specific duties of the subcontractor relating to coordination of benefits and determination of third party liability.
g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to CRSA.
h. A description of the subcontractor's patient, medical and cost record keeping system.
i. Specification that the subcontractor shall cooperate with quality improvement programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the *AMPM*.
j. A provision stating that a merger, reorganization or change in ownership of a subcontractor that is related to or affiliated with CRSA shall require a contract amendment and prior approval of AHCCCS.
k. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.
l. A provision that the subcontractor must obtain any necessary authorization from CRSA for services provided to CRS eligible individuals and/or CRS recipients.
m. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
n. A provision that the subcontractors must submit standardized, detailed financial statements on a quarterly and annual basis to CRSA. Clinic subcontractors must have an annual financial audit conducted by an independent CPA.
o. A provision that emergency services do not need prior authorization and that, in utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a "prudent layperson" is defined as a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interest and the interests of others. The phrase does not apply to a person's ability to reason, but rather the prudence with which he acts under a given set of circumstances.
p. A provision that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individuals or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].
q. Provision(s) that allow CRSA to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation [42 CFR 438.230(b)(4)].

CRSA shall be held fully liable for the performance of all contract requirements contained herein and shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms [42 CFR 438.230(a) and 434.6(c)]. CRSA shall advise AHCCCS in writing within five working days of any subcontractor non-compliance and of the corrective measures taken, including the amount and duration of sanctions, to ensure subsequent compliance [42 CFR 438.230(b)(4)].

CRSA shall include provisions in its subcontracts that allow it to suspend, deny, refuse to renew, or terminate any subcontracts in accordance with the terms of this contract and applicable law and regulations. CRSA will, in addition to these remedies, impose financial sanctions on subcontractors for failure to perform as required, failure to submit timely and accurate reports, engaging in actions which jeopardize Federal Financial Participation or for any other breach of the terms of this contract [42 CFR 438.230(b)(2)]. Written notice must be provided to the subcontractor specifying the grounds for sanction, the amount of funds to be withheld from capitation payments and steps necessary to avoid future

sanctions. Other sanctions may be imposed against the subcontractors and their service providers in accordance with defined CRSA policies.

All subcontracts shall include terms describing the circumstances under which CRSA would be authorized to step in and operate the subcontractor directly. Where warranted, CRSA shall, after delivering appropriate notice to the deficient subcontractor, operate the subcontractor for only so long as it is necessary to assure delivery of uninterrupted care to recipients, transition the recipients to a new subcontractor, or until the deficient subcontractor corrects all deficiencies.

38. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

CRSA shall develop and maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes and appeals. [42 CFR 438.242(a)]

CRSA will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least six months before the anticipated implementation date, the contractor shall provide the system change plan to AHCCCS for review and comment.

The CRSA shall develop and implement an internal claims audit function that will include the following:

- Verification that provider contracts are loaded correctly
- Accuracy of payments against provider contract terms

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §§ 36-2903 and 2904 and AHCCCS Rules R9-22 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related Policy requirements as needed.

The contractor must include nationally recognized methodologies to correctly pay claims including but not limited to:

- Correct Coding Initiative (CCI) for Professional and Outpatient services;
- Multiple Surgical Reductions;
- Global Day Bundling;
- Multi Channel Lab Test Bundling

The Contractor claims payment system must be able to assess and/or apply the following data related edits:

- Benefit Package Variations;
- Timeliness Standards;
- Data Accuracy;
- Adherence to AHCCCS Policy;
- Provider Qualifications;
- Member Eligibility and Enrollment;
- Over-Utilization Standards

This system must produce a remittance advice related to the Contractor's payments and/or denials to providers and must include, at a minimum:

- an adequate description of all denials and adjustments
- the reasons for such denials and adjustments

- the amount billed
- the amount paid
- application of COB
- provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). The remittance advice sent related to an EFT must be mailed, or sent to the provider, no later than the date of the EFT. If the remittance is made through EFT, a notice of the provider's right for claim dispute must be sent to the provider concurrently.

CRSA or its subcontractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by AHCCCS, Division of Health Care Management, Acute Care Operations Unit. If AHCCCS does not respond within 30 days; the recoupment request is deemed approved. AHCCCS must be notified of any cumulative recoupment greater than $50,000 per provider per contract year. A subcontractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim, without prior approval from AHCCCS, as further described in the ACOM *Recoupment Request Policy*.

CRSA or its subcontractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. AHCCCS will validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. The Contractor should refer to the ACOM *Recoupment Request Policy* and AHCCCS *Encounter Reporting User Manual* for further guidance.

CRSA shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a shorter time period is specified in contract, the subcontractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service, except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the subcontractor's specified claim mailing address. The paid date of the claim is the date on the check or other form of payment. [42 CFR 447.45(d)] Claims submission deadlines shall be calculated from the claim end date or the effective date of eligibility posting, whichever is later as stated in A.R.S. 36-2904.H.

Effective for all non-hospital clean claims, in the absence of a contract specifying other late payment terms, CRSA is required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 2903.01. When interest is paid, the subcontractor must report the interest as directed in the Encounter Manual.

If the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

AHCCCS will require the Contractor to participate in an AHCCCS workgroup to develop uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, including billing rules and documentation requirements. The workgroup may be facilitated by an AHCCCS selected consultant. The Contractor will be held responsible for the cost of this project based on its share of AHCCCS enrollment.

CRSA subcontractors are required to accept HIPAA compliant electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. In addition, subcontractors shall implement and meet the following milestone in order to make claims processing and payment more efficient and timely:

a. Subcontractors must be able to make claims payments via electronic Funds Transfer.
b. Subcontractors are required to receive and pay 25% of all claims [based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs)] electronically.

In accordance with the Deficit Reduction Act of 2005, Section 6085, CRSA is required to reimburse non-contracted emergency services providers at no more than the AHCCCS Fee-For-Service rate. This applies to in state as well as out of state providers.

In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, CRSA is required to reimburse non-contracted non-emergent in state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at ninety-five percent of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

CRSA shall submit a monthly Claims Dashboard as specified in the AHCCCS *Claims Dashboard Reporting Guide*. The Monthly report must be received by AHCCCS, Division of Healthcare Management, no later than 15 days from the end of each month.

CRSA must review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS no later than January 1, 2009, that will include the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

39. RESERVED

40. RESERVED

41. RESERVED

42. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives: Reporting of Physician Incentive Plan has been suspended by CMS until further notice. No reporting is required until suspension is lifted.

CRSA or its subcontractors must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479. These regulations prohibit physician incentive plans that directly or indirectly make payments to a doctor or a group as an inducement to limit or refuse medically necessary services to a member. CRSA or its subcontractors are required to disclose all physician incentive agreements to AHCCCS and to CRS recipients who request them.

CRSA or its subcontractors shall not enter into contractual arrangements that place providers at significant financial risk as defined in 42 CFR 417.479 unless specifically approved in advance by the AHCCCS, Division of Health Care Management. In order to obtain approval, the following must be submitted to the AHCCCS, Division of Health Care Management 45 days prior to the implementation of the contract [42 CFR 438.6(g)]:

1. A complete copy of the contract;
2. A plan for the recipient satisfaction survey;
3. Details of the stop-loss protection provided; and,
4. A summary of the compensation arrangement that meets the substantial financial risk definition.

CRSA or its subcontractors shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS. Please refer to the *Physician Incentive Plan Disclosure by Contractors Policy* for details on providing required disclosures.

CRSA or its subcontractors shall also provide for compliance with physician incentive plan requirements as set forth in 42 CFR 422.208, 422.210 and 438.6(h). These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

Pay for Performance: Any pay for performance that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management, prior to implementation.

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

If a CRSA has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS upon request. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made.

If there is a change in ownership of the entity with which the CRSA has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two Contractors to utilize the same management service company in the same GSA.

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 37, Subcontracts and Attachment F: Periodic Report Requirements.

44. FINANCIAL OPERATIONS

CRSA shall ensure that it and each subcontractor has a system to produce complete, timely, reliable and accurate financial records in accordance with contract requirements for financial reporting as specified in the CRSA Financial Reporting Guide. Each subcontractor shall design and implement its financial operations system to ensure compliance with Generally Accepted Accounting Principles. Each subcontractor shall also file with CRSA an annual (more frequently if required by CRSA) CMS approved disclosure statement and related party transactions statement. CRSA shall evaluate all such statements to ensure that they conform to CMS requirements and, through its periodic audit and review procedures, shall ensure that the statements are complete and accurate. CRSA shall take immediate corrective action upon discovery of any failure to meet contract requirements.

45. TERMS OF AUTHORIZATION AND BUDGET CAP

AHCCCS will not be responsible for costs incurred by CRSA that exceed the budget cap associated with its legislative appropriation.

Federal funds provided under the annual authorization addressed above shall be available for the term defined in the annual authorization. If at any time during the term of this contract CRSA determines that the funding authorization is insufficient; CRSA shall notify AHCCCS in writing and shall include in the notice recommendations as to resolution of the shortage.

46. RESERVED

47. RESERVED

48. RESERVED

49. RESERVED

50. FINANCIAL VIABILITY STANDARDS

AHCCCS has established the following financial viability standard/performance guidelines as applicable to CRSA and the subcontractors' financial performance. These guidelines are analyzed as part of AHCCCS's due diligence in contract oversight. On a quarterly and annual basis, AHCCCS will review, among other items, the following:

Measures	How Measured	Target	Data Source	Frequency of Calculation
Balance Sheet Viability Ratios				
Current Ratios	Current Assets Divided by Current Liabilities	Not less than 1.0	Financial Statements of contracted entity	Quarterly
Income Statement Viability Ratios				
Administrative Expenses to AHCCCS Revenues	Administrative Expenses as a percent of AHCCCS Revenues	Not more than 35% of AHCCCS Revenues	Financial Statement of Contracted Entity	Quarterly-Contract YTD

51. RESERVED

52. RESERVED

53. COMPENSATION

Capitation Payments: AHCCCS will pay CRSA a per recipient per month capitation rate for all prospective recipient months as determined by AHCCCS, including partial recipient months. AHCCCS will make monthly capitation payments to CRSA for each CRS recipient on the first of the month based on the previous month's AHCCCS/CRS recipient count. Payment shall be made not later than the end of the month for the previous month for which payment is due.

After the close of the final month of thecontract, reconciliation will be made for the final month's recipient months adjusted by the payments made during the first month of the contract.

CRSA will be paid a high, medium, or low capitation rate per region, pursuant to the CRS recipient's classification of region-specific high, medium, or low risk as defined by CRSA. Capitation rates represent the cost of providing covered CRS services to the CRS recipient. The capitation received by CRSA shall represent payment in full for any and all covered services provided to the recipient, including the CRSA regional subcontractor administrative costs.

All funds received by CRSA and its subcontractors pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles and procedures.

An error discovered by the State with or without an audit in the amount of fees paid to CRSA will be subject to adjustment or repayment by CRSA by making a corresponding decrease in a current payment or by making an additional payment by AHCCCS to CRSA.

Payments made by AHCCCS to CRSA are conditioned upon the receipt by AHCCCS of applicable, accurate and complete reports required to be submitted by CRSA under this contract.

Requests for Federal financial participation (FFP) from CRSA, and the pass through of Title XIX and Title XXI funds to CRSA from AHCCCS, shall both adhere to the mandatory Cash Management Improvement Act (CMIA) of 1990 as established by the General Accounting Office of the Arizona Department of Administration (GAO/ADOA).

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or S-Chip, except for emergency services [Section 1932(d)(4) of the Social Security Act].

Establishment of Intergovernmental Agreement (IGA) Fund: CRSA shall, on an annual basis, transfer to AHCCCS the total amount appropriated for the state match for Title XIX AHCCCS expenditures. This transfer shall be made, in its entirety, prior to the first Title XIX disbursement. If CRSA is unable to roll forward its entire fiscal year allotment prior to the due date of the first Title XIX disbursement, AHCCCS will accept the receipt of the first quarter's allotment for the first capitation payment. However, the remainder of the annual state match requirement must be received before subsequent payments are made. AHCCCS shall deposit the monies transferred into an IGA Fund of which AHCCCS shall have sole disbursement authority.

When AHCCCS draws FFP for qualifying CRSA disbursements, AHCCCS will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to CRSA.

AHCCCS shall only draw FFP when sufficient state match funds are available. If AHCCCS determines that additional monies are required, AHCCCS shall notify CRSA that additional monies must be deposited into the IGA Fund prior to making additional Title XIX disbursements.

If at the end of a fiscal year, and after the close of any administrative adjustment period as defined in ARS 35-190-191, monies remain in the IGA Fund, AHCCCS shall notify CRSA and transfer these monies back to CRSA. If it is determined that excessive funds exist in the IGA Fund, CRSA may request a withdrawal of monies prior to the end of the state fiscal year and/or prior to the close of the administrative adjustment period.

Capitation Rates: CRSA shall provide AHCCCS with documentation relevant to the capitation rate calculation and is responsible for developing proposed, actuarially sound capitation rates to be paid by AHCCCS for Title XIX and Title XXI members. CRSA shall include AHCCCS in capitation rate development meetings with its actuaries throughout the rate development process. CRSA must submit proposed capitation rates and supporting documentation, including the diagnostic classification of region-specific cost and risk levels, to AHCCCS no later than July 1 of each year, or earlier if necessary to adhere to Federal capitation rate submission guidelines. If AHCCCS does not receive a proposal and supporting documentation for updating capitation rates from CRSA, AHCCCS will use available information to update the rates or, if sufficient data is not available, will maintain rates at existing levels. Neither CRSA nor AHCCCS will consider costs of non-covered services in the development of capitation rates. [42 CFR 438.6(e)]

These rates are developed based on costs, encounters, and utilization information as reported by CRSA. AHCCCS may request CRSA to perform reevaluations of the capitation rates if AHCCCS receives information which varies significantly from the information used to calculate the rates. This change may result in a retrospective rate increase or decrease. Annually, by July 1st, CRSA shall submit to AHCCCS a report analyzing current activity against significant or key assumptions used in development of the previous year capitation rates. The scope of such a report will be mutually agreed upon by CRSA and AHCCCS.

CRSA Administrative Cost Report: CRSA shall provide AHCCCS with a report that details administrative expenditures by CRSA on a semi-annual basis. The format is to be determined.

***Liability for Payment*:** CRSA must ensure that CRS recipients are not held liable for:

a. CRSA or subcontractor's debts in the event of CRSA's or the subcontractor's insolvency;
b. Covered services provided to the CRS recipient, for which AHCCCS does not pay CRSA and CRSA does not pay subcontractors; or,
c. Payments to CRSA or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the CRS recipient would owe if CRSA or the subcontractor provided the services directly.

Administrative costs not directly related to the responsibilities covered by this contract may be eligible for Federal Financial Participation (FFP) at the 50% administrative participation rate. To be eligible, the cost must be determined to be reasonable and necessary for the proper and efficient administration of the Medicaid program. Any costs deemed to be State Medicaid administrative costs shall be reviewed and approved by AHCCCSA and CMS and shall be excluded from capitation rate development.

Currently the only costs this exception applies to are actuarial costs for capitation rate development. Federal Financial Participation applicable to administrative expenditures shall be available and the Contractor shall be

responsible for providing the necessary state match. When AHCCCSA draws FFP for qualifying disbursements, including these under the administrative FFP rate, AHCCCSA will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to ADHS.

54. RESERVED

55. CAPITATION ADJUSTMENTS

Any recoupments imposed by the Federal government and passed through to CRSA shall be reimbursed to AHCCCS upon demand.

56. RESERVED

57. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered services, as described below, for a Title XIX or Title XXI eligible CRS member with an acute medical CRS condition with expenditures beyond an annual deductible level. AHCCCS funds the reinsurance program through a deduction to capitation rates that is intended to be budget neutral. Section D, Paragraph 53, Compensation, provides detail on the pass through of funds to CRS from AHCCCS through the Intergovernmental Agreement (IGA) Fund.

Refer to the *AHCCCS Reinsurance Processing Manual* for further details on the Reinsurance Program.

Inpatient Reinsurance

Inpatient reinsurance covers partial reimbursement of covered inpatient facility medical services. See the table below for applicable deductible levels and coinsurance percentages. The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered inpatient services incurred above the deductible. The deductible is the responsibility of the Contractor. Per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage.

The following table represents deductible and coinsurance levels:

Annual Deductible	*Coinsurance*
$75,000	75%

Beginning October 1, 2009, and annually thereafter, the deductible levels above will increase by $5,000.

Catastrophic Reinsurance

The reinsurance program includes a special Catastrophic Reinsurance program. This program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with Gaucher's Disease. For additional detail and restrictions refer to the *AHCCCS Reinsurance Processing Manual* and the *AMPM*. There are no deductibles for catastrophic reinsurance cases. For those members diagnosed with Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, depending on the subcap code. For members receiving certain biotech drugs listed below, only the drug costs will be covered

under the Catastrophic Reinsurance Program. All catastrophic claims are subject to medical review by AHCCCS.

The Contractor shall notify AHCCCS, Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of (a) initial diagnosis, (b) enrollment with the Contractor, and (c) the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria; 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

GAUCHER'S DISEASE: Catastrophic reinsurance is available for members diagnosed with Gaucher's Disease classified as Type I and who are dependent on enzyme replacement therapy.

BIOTECH DRUGS: Effective October 1, 2008, catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor when used in the treatment of a CRS covered condition. Catastrophic reinsurance will cover the drug cost only. The drugs covered are Cerazyme, Aldurazyme, Fabryzyme, Myozyme, Orfadin, Kuvan and Elaprase. The Biotech Drugs covered under reinsurance will be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug cost or its generic equivalent for reinsurance purposes.

Other

For inpatient, Gaucher's disease and biotech drugs, Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case total value meets or exceeds $650,000 (total health plan paid amount including the deductible). Once this level is met, the Contractor must notify, via email, the AHCCCS Reinsurance Supervisor in order to receive enhanced Reinsurance benefits. Reinsurance Case Approved Amounts over $650,000 are transferred to a newly manually created case per the request of the Contractor. The Contractor is required to split encounters as necessary once the reinsurance case reaches $650,000. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date or service will disqualify the related encounters for 100% reimbursement consideration.

Encounter Submission and Payments for Reinsurance

a) Encounter Submission: A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor certifies that the services listed were actually rendered. The encounters must be submitted in the format prescribed by AHCCCS. The Contractor must initiate and evaluate an encounter for probable 1st and 3rd party liability before submitting the encounter for reinsurance consideration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st and 3rd party liability insurance or a tort feasor.

The Contractor must maintain evidence that costs incurred have been paid by the Contractor before submitting reinsurance encounters. This information is subject to AHCCCS review. Collections from 1st and 3rd parties should be reflected by the Contractor as reductions in the encounters submitted on a dollar-for-dollar basis. For purposes of AHCCCS reinsurance, payments made by Contractor-purchased reinsurance are not considered 1st and 3rd party collections.

All reinsurance claims must reach a clean claim status within fifteen months from the end date of service, or date of eligibility posting, whichever is later. Encounters for reinsurance claims that have passed the fifteen month deadline and are being adjusted due to a claim dispute or hearing decision must be submitted and pass

all encounter and reinsurance edits within 90 calendar days of the date of the claim dispute decision or hearing decision, whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss of any related reinsurance dollars.

b) Encounter Processing: AHCCCS will accept for processing only those encounters that are submitted directly by an AHCCCS Contractor and that comply with the *AHCCCS Encounter Reporting User Manual*.

c) Payment of Inpatient and Catastrophic Reinsurance Cases: AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the Contractor, minus the coinsurance and Medicare/TPL payment, unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, the Administration shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest. Reimbursement for these reinsurance benefits will be made to the Contractor each month.

Reinsurance Audits

Pre-Audit: Medical audits on reinsurance cases may be conducted. The Division of Health Care Management will select reinsurance cases based on encounter data received during the contract year to assure timeliness of the audit process. The Contractor will be notified of the documentation required for the medical audit.

Audit: AHCCCS will give the Contractor at least 45 days advance notice of any audit. The Contractor shall have all requested medical records and financial documentation available to the nurse auditors. Any documents not requested in advance by AHCCCS shall be made available upon request of the Audit Team during the course of the audit. The Contractor representative shall be available to the Audit Team at all times during AHCCCS audit activities. If an audit should be conducted on-site, the Contractor shall provide the Audit Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

Audits may be completed without an on-site visit. For these audits, the Contractor will be asked to send the required documentation to AHCCCS. The documentation will then be reviewed by AHCCCS.

Audit Considerations: Reinsurance consideration will be given to inpatient facility contracts and hearing decisions rendered by the Office of Legal Assistance. Pre-hearing and/or hearing penalties discoverable during the review process will not be reimbursed under reinsurance.

Per diem rates may be paid for nursing facility and rehabilitation services provided the services are rendered within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year. The services rendered in these sub-acute settings must be of an acute nature and, in the case of rehabilitative or restorative services, steady progress must be documented in the medical record.

Audit Determinations: The Contractor will be furnished a copy of the Reinsurance Post-Audit Results letter approximately 45 days after the audit and given an opportunity to comment and provide additional medical or financial documentation on any audit findings. AHCCCS may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the Contractor. A recoupment of reinsurance reimbursements made to the Contractor may occur based on the results of the medical audit.

A Contractor whose reinsurance case is reduced or denied shall be notified in writing by AHCCCS and will be informed of rationale for reduction or denial determination and the applicable grievance and appeal process available.

58. COORDINATION OF BENEFITS

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. CRSA shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by CRSA are cost avoided or recovered from a liable party. The term "State" shall be interpreted to mean "CRSA" for purposes of complying with the federal regulations referenced above. The CRSA may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

AHCCCS shall require all AHCCCS members with a CRS eligible medical condition, without private insurance, to enroll with CRS. For those members with a CRS eligible condition, with private insurance, enrollment with CRS shall be optional. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. Members with private insurance choosing not to enroll with CRS may seek the payment of applicable copays and deductibles from the health plan/program contractor with whom they are enrolled. When the private insurance is exhausted with respect to CRS covered conditions, the health plan/program contractor is required to refer the member to CRSA for determination for CRS services. For those members with private insurance who are enrolled in the CRS program, CRSA or its subcontractor is responsible for applicable copays and deductibles related to the CRS condition.

The two methods used in the coordination of benefits are cost avoidance and post payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq. and federal and state law. See also Section D, Paragraph 60 Medicare Services and Cost Sharing.

Cost Avoidance: The Contractor shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost-avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post payment recovery which is described in further detail below. If the Administration determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions in an amount not less than **three times** the amount that could have been cost avoided.

The Contractor shall not deny a claim for untimeliness if the untimely claim submission results from a provider's efforts to determine the extent of liability.

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the Contractor is responsible for making these payments, even if the services are provided outside of the Contractor network. The Contractor is not responsible for paying coinsurance and deductibles that are in excess of what the Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS FFS payment equivalent when no contract exists. If the Contractor refers the member for services to a third-party insurer, other than Medicare, and the insurer requires payment in advance of all copaycopayments, coinsurance and deductibles, the Contractor must make such payments in advance.

Post-payment Recoveries: Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable party at the time services were rendered or paid for, or was unable to cost-avoid.The following sections set forth requirements for Contractor recovery actions including recoupment activities, other recoveries and total plan case requirements.

Recoupments: The Contractor must follow the protocols established in the ACOM *Recoupment Request Policy*. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the Contractor must submit replacement encounters.

Other Recoveries: The Contractor shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 799.9 and 800 to 999.9 (excluding code 994.6), and other procedures. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS's authorized representative:

Uninsured/underinsured motorist insurance
First-and third-party liability insurance
Tortfeasors, including casualty
Special Treatment Trust Recovery
Restitution Recovery
Worker's Compensation
Estate Recovery

Upon identification of any of the above situations, the Contractor shall promptly report cases to AHCCCS's authorized representative for determination of a "total plan" case. The Contractor is responsible for all recovery actions for a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or fee-for-service payments are involved. By contrast, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Contractor shall notify AHCCCS's authorized representative within 10 business days of the identification of a liable party. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. The Contractor shall cooperate with AHCCCS's authorized representative in all collection efforts.

Total Plan Case Requirements: In "total plan" cases, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. 36-2915 and A.R.S. 36-2916. The Contractor shall use the AHCCCS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The Contractor may retain up to 100% of its recovery collections if all of the following conditions exist:

a. Total collections received do not exceed the total amount of the Contractor's financial liability for the member;
b. There are no payments made by AHCCCS related to fee-for-service, reinsurance or administrative costs (i.e., lien filing , etc.); and
c. Such recovery is not prohibited by state or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that there is no reinsurance or fee-for-service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Total Plan Cases: the Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Notification of Settlement form, within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Joint Cases: AHCCCS's authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS's authorized representative by the Contractor. In joint cases, AHCCCS's authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement in joint cases and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Contractor will be responsible for their prorated share of the contingency fee. The Contractor's

share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Contractor.

Other Reporting Requirements: If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. In addition, the Contractor shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the *Technical Interface Guidelines*. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

At AHCCCS's request, the Contractor shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to the Contractor. AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as decribed in the *Technical Interface Guidelines.*

Title XXI (KidsCare), HIFA Parents, BCCTP, SOBRA Family Planning and SSDI-TMC: Eligibility for KidsCare, HIFA Parents, BCCTP, SOBRA Family Planning and SSDI-TMC benefits require that the applicant/member not be enrolled with any other creditable health insurance plan. If the Contractor becomes aware of any such coverage, the Contractor shall notify AHCCCS immediately. AHCCCS will determine if the other insurance meets the creditable coverage definition in A.R.S. 36-2982(G).

Contract Termination: Upon termination of this contract, the Contractor will complete the existing third party liability cases or make any necessary arrangements to transfer the cases to AHCCCS's authorized TPL representative.

59. COPAYMENTS

Most of the AHCCCS members remain exempt from copayments while others are subject to an optional copayment. Those populations exempt or subject to optional copayments may not be denied services for the inability to pay the copayment [42 CFR 438.108].

Any copayments collected shall belong to the Contractor or its subcontractors.

Attachment L, Copayments, provides detail of the populations and their related copayment structure.

60. MEDICARE SERVICES AND COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligible". Generally, Contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. Unless prior approval is obtained from AHCCCS, CRSA must limit the cost sharing responsibility according to the ACOM *Medicare Cost Sharing Policy*. CRSA shall have no cost sharing obligation if the Medicare payment exceeds what CRSA would have paid for the same service of a non-Medicare member.

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay co-payments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to the Center for Medicare and

Medicaid Services (CMS), the Contractor must, using the approved form, notify the AHCCCS Member File Integrity Section (MFIS), via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

a. Members who have Medicare part "B" only;
b. Members who have used their Medicare part "A" life time inpatient benefit;
c. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.

For purposes of the medical institution notification, medical institutions are defined as acute hospitals, psychiatric hospital – Non IMD, psychiatric hospital – IMD, residential treatment center – Non IMD, residential treatment center – IMD, skilled nursing facilities, and Intermediate Care Facilities for the Mentally Retarded.

61. RESERVED

62. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, CRSA is required to immediately notify the AHCCCS Office of Program Integrity regarding any suspected fraud and report the information within 10 business days of discovery by completing the confidential AHCCCS Referral for Preliminary Investigation form for any and all suspected fraud or abuse. [42 CFR 455.1(a)(1)] This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, CRSA, subcontractors or providers.

As stated in A.R.S. Section 13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material omissions is guilty of a Class 2 felony.

CRSA agrees to permit and cooperate with any onsite review. A review by the AHCCCS, OPI may be conducted without notice and for the purpose of ensuring program compliance. CRSA also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS Administration. CRSA agrees to provide documents, including original documents, to representatives of the Office of Program Integrity upon request. The OPI shall allow a reasonable time for the CRSA to copy the requested documents, not to exceed 20 business days from the date of the OPI request.

CRSA and the subcontractors shall be in compliance with 42 CFR 438.608. CRSA and the subcontractors must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. CRSA shall have written criteria for selecting a Compliance Officer and a job description that clearly outlines the responsibilities and the authorities of the position. The Compliance Officer shall have the authority to access records and independently refer suspected member fraud, provider fraud and member abuse cases to AHCCCS, OPI or other duly authorized enforcement agencies.

The compliance program shall be designed to both prevent and detect suspected fraud or abuse. The compliance program must include:

1. The written designation of a compliance officer and a compliance committee that are accountable to CRSA top management.
2. The Compliance Officer must be an onsite management official who reports directly to top management.
3. Effective training and education.

4. Effective lines of communication between the compliance officer and the organization's employees.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Provision for internal monitoring and auditing.
7. Provision for prompt response to problems detected.
8. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and state standards.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with decision making authority. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), CRSA, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. CRSA must establish a process for training existing staff and new hires on the compliance program and on the items in section 10. All training must be conducted in such a manner that can be verified by AHCCCS.
12. CRSA must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions:
    a. The administrative remedies for false claims and statements;
    b. Any state laws relating to civil or criminal penalties for false claims and statements;
    c. The whistleblower protections under such laws.

CRSA and the subcontractors are required to research potential overpayments identified by the AHCCCS, Office of Program Integrity. [42 CFR 455.1(a)] After conducting a cost benefit analysis to determine if such action is warranted, CRSA should attempt to recover any overpayments identified. The AHCCCS Office of Program Integrity shall be advised of the final disposition of the research and advised of actions, if any, taken by CRSA.

63. RECORDS RETENTION

The Contractor shall maintain records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor agrees to make available, at all reasonable times during the term of this contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the reproduction of requested information.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract. HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j)(2).

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Contractor for a period of five years after the date of final disposition or resolution thereof.

64. DATA EXCHANGE REQUIREMENTS

CRSA is authorized to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided AHCCCS in the formats prescribed by AHCCCS , which includes formats prescribed by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the *HIPAA Transaction Companion Documents & Trading Partner Agreements, the AHCCCS Encounter Reporting User Manual* and in the AHCCCS *Technical Interface Guidelines,* available on the AHCCCS website.

The information so recorded and submitted to AHCCCS shall comply with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following appropriate notification to AHCCCS.

CRSA is responsible for any incorrect data, delayed submission or payment (to CRSA or by CRSA to its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CRS-submitted data. Any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS. CRSA shall not be responsible for any incorrect data or delays caused by AHCCCS.

CRSA is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCS. If any unreported inconsistencies are subsequently discovered, CRSA shall be responsible for the necessary adjustments to correct its records at its own expense.

CRSA shall accept from AHCCCS original evidence of eligibility and enrollment in a form appropriate for electronic data exchange. Upon request by AHCCCS, CRSA shall provide to AHCCCS updated date-sensitive subcontractor assignments in a form appropriate for electronic data exchange.

AHCCCS shall provide CRSA a subcontractor-specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by CRSA shall include the CRSA security code. By use of its security code, CRSA certifies that any data transmitted is accurate and truthful, to the best of the CRSA Administrator/CEO/COO or designee's knowledge [42 CFR 438.606]. Both parties agree to indemnify and hold harmless each other from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by their submitted data. AHCCCS shall not be responsible for any incorrect or delayed payment by CRSA to its AHCCCS services providers (contractors) resulting from such error, omission, deletion, or erroneous input data caused by CRSA in the submission of AHCCCS claims.

The costs of software changes are included in administrative costs paid to CRSA. There is no separate payment for software changes. A PMMIS systems contact will be assigned after the contract has been signed. AHCCCS will work with CRSA as they evaluate Electronic Data Interchange options.

Health Insurance Portability and Accountability Act (HIPAA): CRSA shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of

CRSA by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

65. ENCOUNTER DATA REPORTING

Encounter Submissions

The accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. The Contractor shall submit encounter data to AHCCCS for all services for which the Contractor incurred a financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred, including services provided during prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)].

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor certifies that the services listed were actually rendered [42 CFR 455.1(a)(2)]. The encounters must be submitted in the format prescribed by AHCCCS.

Encounter data must be provided to AHCCCS as outlined in the *HIPAA Transaction Companion Documents & Trading Partner Agreements* and the *AHCCCS Encounter Reporting User Manual* and should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Refer to Paragraph 64, Data Exchange Requirements, for further information.

The Contractor will be assessed sanctions for noncompliance with encounter submission requirements.

Encounter Reporting

An Encounter Submission Tracking Report (ESTR) must be maintained and made available to AHCCCS upon request. The Tracking Report's purpose is to link each claim to an adjudicated or pended encounter returned to the Contractor. Further information regarding the Encounter Submission Tracking Report may be found in the *AHCCCS Encounter Reporting User Manual*.

In addition to the Encounter Submission Tracking Report, the Contractor must maintain and review a report which reconciles financial fields of a claim (health plan paid, billed amount, health plan allowed, etc.) with the financial fields of adjudicated encounters. This report shall be available to AHCCCS upon request.

At least twice each month, AHCCCS provides the Contractor with full replacement files containing provider and medical coding information. These files should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the *AHCCCS Encounter Reporting User Manual* for further information.

Pended Encounter Corrections

The Contractor must resolve all pended encounters within 120 days of the original processing date. Sanctions will be imposed according to the following schedule for each encounter pended for more than 120 days unless the pend is due to AHCCCS error:

0 – 120 days	121 – 180 days	181 – 240 days	241 – 360 days	361 + days
No sanction	$ 5 per month	$ 10 per month	$ 15 per month	$ 20 per month

"AHCCCS error" is defined as a pended encounter, which (1) AHCCCS acknowledges to be the result of its own error, and/or (2) requires a change to the system programming, an update to the database reference table,

or further research by AHCCCS. AHCCCS reserves the right to adjust the sanction amount if circumstances warrant. Upon completion of any changes to the AHCCCS system programming or updates to the database reference tables, sanctions may be imposed from date of resolution. AHCCCS reserves the right to adjust the sanction amount if circumstances warrant.

Before imposing sanctions, AHCCCS will notify the Contractor, in writing, of the total number of sanctionable encounters pended more than 120 days. Pended encounters shall not be voided by the Contractor as a means of avoiding sanctions for failure to correct encounters within 120 days. The Contractor shall document voided encounters and shall maintain a record of the voided Claim Reference Number(s) (CRN) with appropriate reasons indicated. The Contractor shall, upon request, make this documentation available to AHCCCS for review. Refer to the *AHCCCS Encounter Reporting User Manual* for further information.

Encounter Corrections

Contractors are required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission as described below. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. For those recoupments requiring approval from AHCCCS, replacement encounters must be submitted within 120 days of the recoupment approval from AHCCCS. Refer to the AHCCCS *Encounter Reporting User Manual* for instructions regarding the submission of corrected encounters.

Encounter Validation Studies

Per the CMS requirement, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions, and sanction the Contractor for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. Encounter validation studies will be conducted at least yearly.

AHCCCS may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with CMS. The Contractor will be notified in writing of any significant change in study methodology.

AHCCCS will notify the Contractor in writing of the sanction amounts and of the selected data needed for encounter validation studies. The Contractor will have 90 days to submit the requested data to AHCCCS. In the case of medical records requests, the Contractor's failure to provide AHCCCS with the records requested within 90 days may result in a sanction of $1,000 per missing medical record. If AHCCCS does not receive a sufficient number of medical records from the Contractor to select a statistically valid sample for a study, the Contractor may be sanctioned up to 5% of its annual capitation payment.

The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the *AHCCCS Data Validation User Manual* for further information.

AHCCCS may also perform special reviews of encounter data, such as comparing encounter reports to the Contractor's claims files. Any findings of incomplete or inaccurate encounter data may result in the imposition of sanctions or requirement of a corrective action plan.

66. RECIPIENT ROSTER RECONCILIATION

Recipient Roster: CRSA shall transmit, no less than monthly, via electronic transfer the names of recipients currently CRS eligible, or were CRS eligible at any time in the last six months, for which CRS provides

covered services. CRSA shall screen individuals who are added to verify that they are eligible. This automated notification process shall include the following information:

a. Information to identify the recipient;
b. Effective dates for covered services; and,
c. CRSA subcontractor to which the recipient is assigned and the assigned risk level.

67. PERIODIC REPORT REQUIREMENTS

AHCCCS, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data, and other information from CRSA. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in this contract. Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242 (b)(2)]:

1. *Timeliness* - Reports or other required data shall be received on or before scheduled due dates.
2. *Accuracy* - Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and AHCCCS defined standards.
3. *Completeness* - All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. CRSA shall comply with all changes specified by AHCCCS.

CRSA shall be responsible for continued reporting beyond the term of the contract.

68. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from CRSA. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of CRSA except as required by law. Upon receipt of such written requests for information, CRSA shall provide complete information as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself or subsequently agreed to by AHCCCS and CRSA.

69. DISSEMINATION OF INFORMATION

Upon request, CRSA shall assist AHCCCS in the dissemination of information prepared by AHCCCS or the Federal government to its recipients. The cost of such dissemination shall be borne by CRSA. All advertisements, publications and printed materials that are produced by CRSA and refer to covered services shall state that such services are funded under contract with AHCCCS.

70. RESERVED

71. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS Special Terms and Condition and the BBA requirements, AHCCCS, or an independent external agent, will conduct Operational and Financial Reviews to ensure operational and financial program compliance [42 CFR 438.240(e)(2)]. The reviews will identify areas where improvements can be made and make recommendations accordingly, to monitor CRSA's progress towards

implementing mandated programs and provide CRSA with technical assistance if necessary. CRSA shall comply with all other medical audit provisions as required by AHCCCS Rule R9-22-521 and R9-31-522.

The type and duration of the Operational and Financial Review will be solely at the discretion of AHCCCS. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will notify CRSA at least three weeks in advance of the date of the on-site review. In preparation for the on-site Operational and Financial Reviews, CRSA shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, logs and other information that AHCCCS may request. CRSA shall have all requested medical records on-site. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. CRSA personnel as identified in advance shall be available to the Review Team at all times during AHCCCS on-site review activities. While on-site, CRSA shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

CRSA will be furnished a draft copy of the Operational and Financial Review Report and given an opportunity to comment on any review findings prior to AHCCCS publishing the final report. Recommendations, made by the Review Team to bring CRSA into compliance with Federal, State and AHCCCS, and/or contract requirements, must be implemented by CRSA. AHCCCS may conduct a follow-up Operational and Financial Review to determine CRSA's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial Operational and Financial Review.

AHCCCS may conduct an Operational and Financial Review in the event CRSA undergoes reorganization or makes changes in three or more key staff positions within a 12-month period.

In addition to the annual Operational and Financial Review AHCCCS may conduct unannounced site visits to monitor contractual requirements and performance as needed.

72. SANCTIONS

AHCCCS may impose monetary sanctions, suspend, deny, refuse to renew, or terminate this contract or any related CRSA subcontracts in accordance with AHCCCS Rule R9-22-606, ACOM, *Sanctions Policy*, the terms of this contract and applicable Federal or State law and regulations. [42 CFR 422.208, 42 CFR 438.700, 702, 704, and 45 CFR 92.36(i)(1)] Written notice will be provided to CRSA specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld. AHCCCS will prepare the AHCCCS side of the GAO-614 transfer documents and forward them to CRSA to complete its side of the transactions. One transfer will reduce the Federal Share of the capitation payment and the second transfer document is intended for CRSA to account for their state match sanction expenditure funded by a state match source chosen by CRSA. A copy of the transfer document will be sent with the monthly capitation payment to notify CRSA that the sanction has taken place. CRSA may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. 9-34-401 et seq. Intermediate sanctions may be imposed for, but not limited to, the following actions:

a. Substantial failure to provide medically necessary services that CRSA is required to provide under the terms of this contract.
b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
c. Discrimination among CRS recipients on the basis of their health status of need for health care services.

d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
e. Misrepresentation or falsification of information furnished to a recipient, potential recipient, or provider.
f. Failure to comply with the requirement for physician incentive plan as delineated in Paragraph 54
g. Failure to meet AHCCCS Financial Viability Standards.
h. Material deficiencies in CRS provider network.
i. Failure to meet quality of care and quality management requirements.
j. Failure to meet AHCCCS encounter standards.
k. Violation of other applicable State or Federal laws or regulations.
l. Failure to require subcontractors to increase the Performance Bond in a timely manner.
m. Failure to comply with any provisions contained in this contract.
n. Failure to report third party liability cases as described in paragraph 30.

AHCCCS may impose the following types of intermediate sanctions:

a. Civil monetary penalties.
b. Appointment of temporary management for CRSA as provided in 42 CFR 438.706 and A.R.S. §36-2903 (M).
c. Suspension of payment for recipients after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
d. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process: Prior to the imposition of a sanction for non-compliance, AHCCCS may provide a written cure notice to CRSA regarding the details of the non-compliance. The cure notice will specify the period of time during which CRSA must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, CRSA has complied with the cure notice requirements, AHCCCS will take no further action. If, however, CRSA has not complied with the cure notice requirements, AHCCCS will proceed with the imposition of sanctions. Refer to the ACOM *Sanctions Policy* for details.

Automatic Sanctions: AHCCCS will assess the sanctions listed in Attachment F, Periodic Reporting Requirements on deliverables listed under DHCM Acute Care Operations, Clinical Quality Management and Medical Management that are not received by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, sanctions will be assessed on deliverables not received by 5:00 PM on the next business day.

The Administration shall impose on CRSA any financial penalties or disallowances imposed on the State by the Federal government related to CRSA's performance under this Agreement. The imposition of these sanctions upon CRSA shall not be levied until such time as the Federal government shall have actually imposed sanctions upon the State for conduct related to CRSA's performance under this Agreement. The Administration shall confer with CRSA concerning defenses or objections to the imposition of such sanctions at all stages of the sanction process. In the event that the Federal government imposes sanctions upon the state, CRSA shall reimburse the Administration upon demand, or the Administration will process a transfer (GAO-614) document, any such sanction or disallowance amount or any amount determined by the Federal government to be unallowable, after exhaustion of the appeals process (if Federal regulations so permit) as long as the Federal government does not levy the sanctions until after the appeals process is completed. CRSA shall bear the administrative cost of such an appeals process.

73. BUSINESS CONTINUITY AND RECOVERY PLAN

CRSA shall develop a Business Continuity and Recovery Plan to deal with unexpected events that may affect its ability to adequately serve recipients. This plan shall, at a minimum, include planning and training for:

a. Healthcare facility closure/loss of a major provider;
b. Electronic/telephonic failure at CRSA or its subcontractor's main place of business;
c. Complete loss of use of the main site;
d. Loss of primary computer system/records; and,
e. How CRSA shall communicate with AHCCCS in the event of a business disruption.

The Business Continuity and Recovery Plan shall be reviewed annually and updated as needed. All key staff shall be trained and familiar with the Plan. CRSA shall adhere to all elements of the ACOM *Business Continuity and Recovery Plan* Policy.

CRSA shall ensure subcontractors prepare adequate Business Continuity and Recovery Plan and that the subcontractors review their plans annually, updating them as needed. The subcontractor plans shall, at a minimum, address the areas listed above as they apply to the subcontractors.

74. TECHNOLOGICAL ADVANCEMENT

CRSA and/or the subcontractors must have a website with links to the following information:

1. Formulary;
2. Policies and Procedures;
3. Recipient Handbook;
4. Provider listing;
5. When available, recipient and provider survey results; and,
6. Prior Authorization criteria
7. Evidence Based Medicine Guidelines

In addition to the above, the Contractor must include member related information, as described in the Website section of the ACOM *Member Information Policy* and ACOM *Provider Network Information Policy*, on its website.

The Contractor must be able to perform the following functions electronically:

1. Provide Enrollment Verification in a HIPAA compliant 270/271 format
2. Accept the Benefit Enrollment and Maintenance transaction (834 format)
3. Accept the Payroll Deduction and Other Group Premium Payment for Insurance Products transaction (820 format)
4. Allow Claims inquiry and response in a HIPAA compliant 276/277 format
5. Accept HIPAA compliant electronic claims transactions in the 837 format (See Section D, Paragraph 25, Claims Payment/Health Information System)
6. Generate HIPAA compliant electronic remittance in the 835 format (See Section D, Paragraph 25, Claims Payment/Health Information System)
7. Make Claims payments via electronic funds transfer (See Section D, Paragraph 25, Claims Payment/Health Information System)
8. Acceptance of Prior Authorization requests, in a HIPAA compliant 278 format, no later than 10/01/09. AHCCCS will work with CRSA to develop functionality requirements.

Arizona Health-e Connection

In February of 2007, AHCCCS was awarded a CMS Transformation Grant of $11.7M to build a health information exchange (HIE) and a web based suite of applications for accessing electronic health records (EHR). The HIE will serve to provide real time patient health information and clinical care automation for AHCCCS contracted health care providers, in accordance with the Governor's executive order #2005-25 on Arizona Health-e Connection Roadmap.

AHCCCS will develop a unified approach for AHCCCS health plans and program contractors to meet the goal of the executive order and to connect AHCCCS, AHCCCS Contractors, ancillary subcontractors and registered providers into a common web based electronic health information data exchange that will meet the standards established by State and Federal governments. AHCCCS health plans and program contractors will cooperate in assisting AHCCCS with developing the Health-e project plan and shall implement required data exchange interfaces as required to meet the goals of the Governor's executive order.

CMS will provide grants to state Medicaid agencies to support development of IT infrastructure and applications to achieve the goal of health information data exchange. AHCCCS Contractors will be required to:

1) Encourage lab, pharmacy and ancillary subcontractors to develop common electronic interfaces for the exchange of data using standards based transactions.

2) AHCCCS may issue Minimum Subcontract language that will require subcontractors to participate in the e-Health Initiative. Contractors must amend all provider subcontracts to include the amended Minimum Subcontract provisions within six (6) months of issuance.

AHCCCS will continually work to enhance the functionality of the health information exchange, electronic health records, electronic prescribing, and web based applications. AHCCCS health plan and program contractors are expected to deploy upgrades and enhancements as necessary to participating providers.

75. PENDING LEGISLATIVE / OTHER ISSUES

The following constitute pending items that may be resolved after the issuance of this contract. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of program changes. The items in this paragraph are subject to change and should not be considered all-inclusive.

76. RESERVED

77. ADMINISTRATIVE COORDINATION

CRSA and AHCCCS shall meet periodically to review administrative and operational issues. CRSA shall provide AHCCCS with copies of proposals for legislative changes, Arizona Administrative Code program initiatives and any other policy initiatives that may affect CRS services, coverage or other aspects of medical care.

CRSA shall coordinate with AHCCCS on the development of any Request for Proposals (RFPs) soliciting offers from entities wishing to contract to provide covered services as described in this contract. The coordination shall be designed to ensure that issues relevant to AHCCCS services and members are adequately addressed in the RFPs. CRSA shall submit to AHCCCS for review and comment, the draft CRS RFP for the provision of CRS services at least 45 days prior to release.

78. COLLABORATION

CRSA shall collaborate with AHCCCS in identifying and applying best practices for the community planning process to improve integration of care to enhance the quality of care provided to recipients. CRSA shall collaborate with AHCCCS at minimum, but not limited to, in identifying the scope and goals of this collaborative process.

[END OF SECTION D]

SECTION E: CONTRACT CLAUSES

1) APPLICABLE LAW

Arizona Law - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

2) AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this contract based on those changes.

3) ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract, including all attachments and executed amendments and modifications; AHCCCS policies and procedures.

4) CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State.

5) SEVERABILITY

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

6) RELATIONSHIP OF PARTIES

The Contractor under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

7) ASSIGNMENT AND DELEGATION

The Contractor shall not assign any right nor delegate any duty under this contract without prior written approval of the Contracting Officer, who will not unreasonably withhold such approval.

8) INDEMNIFICATION

Contractor/Vendor Indemnification (Public Agency)

Each party (as "Indemnitor") agrees to indemnify, defend, and hold harmless the other party (as "Indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as "Claims") arising out of bodily injury of any person (including death) or property damage, but only to the extent that such Claims which result in vicarious/derivative liability to the Indemnitee are caused by the act, omission, negligence, misconduct, or other fault of the Indemnitor, its officers, officials, agents, employees, or volunteers.

In addition, the Contractor shall cause its subcontractors, if any, to indemnify, defend, save and hold harmless the State of Arizona, any jurisdiction or agency issuing any permits for any work arising out of this Agreement, and their respective directors, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of the subcontractor or any of the directors, officers, agents, or employees or subcontractors of such contractor. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by such contractor from and against any and all claims. It is agreed that such contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable.

9) INDEMNIFICATION -- PATENT AND COPYRIGHT

The Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

10) COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Executive Order 13166; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits. [42 CFR 438.6(f)(1) and 42 CFR 438.100(d)]

11) ADVERTISING AND PROMOTION OF CONTRACT

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

12) PROPERTY OF THE STATE

Except as provided in this paragraph, any materials, including reports, computer programs and other deliverables, created under this contract are the sole property of AHCCCS. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of AHCCCS.

If the Contractor believes that any reports, computer programs, or other deliverables created under this contract and submitted to AHCCCS contains trade secrets or other proprietary data, the Contractor shall include with the submission a statement that explains and supports the Contractor's claim that the submission contains such information. The Contractor also shall stamp as confidential or otherwise specifically identify in the submission all trade secrets and other proprietary data that the Contractor believes should remain confidential. AHCCCS shall review the statement and information and shall determine whether the information is a trade secret or other proprietary data that shall remain confidential. If AHCCCS determines that the information is not a trade secret or other proprietary data that shall remain confidential, AHCCCS will inform the Contractor in writing of such determination. AHCCCS will not voluntarily disclose any information deemed confidential except as required by law. Before any such disclosures of confidential information are made, AHCCCS will notify the Contractor in writing.

13) THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

14) RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or continue performing this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

15) TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

16) GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

17) SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontractor enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or

from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b)]. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

18) TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, return receipt requested, to the Contractor of the termination at least 90 days before the effective date of the termination. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

19) TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION

Temporary Management and Operation of a Contractor: Pursuant to the Balanced Budget Act of 1997, 42 CFR 438.700 et seq. and State Law ARS §36-2903, AHCCCSA is authorized to impose temporary management for a Contractor under certain conditions. Under federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCSA, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCSA or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCSA determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under federal law, temporary management is mandatory if AHCCCSA determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCSA shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law ARS §36-2903 authorizes AHCCCSA to operate a Contractor as specified in this contract. In addition to the bases specified in 42 CFR 438.700 et seq., AHCCCSA may directly operate the Contractor if, in the judgment of AHCCCSA, the Contractor's performance is in material breach of the contract or the Contractor is insolvent. Under these circumstances, AHCCCSA may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other Contractors. Prior to operation of the Contractor by AHCCCSA pursuant to state statute, the Contractor shall have the opportunity for a hearing. If AHCCCSA determines that emergency action is required, operation of the Contractor may take place prior to hearing. Operation by AHCCCSA shall occur only as long as it is necessary

to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other Contractors, or until the Contractor reorganizes or otherwise corrects contract performance failure.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the Contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

Termination: AHCCCSA reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If the Contractor is providing services under more than one contract with AHCCCSA, AHCCCSA may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCSA reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCSA shall provide the contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCSA on demand.

AHCCCSA may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCSA in re-procuring the materials or services.

20) TERMINATION - AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

21) RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any amounts due the Contractor any expenses or costs incurred by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract.

22) NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCS under this contract are not exclusive.

23) NON-DISCRIMINATION

The Contractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Contractor shall take positive action to ensure that applicants for

employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability.

24) EFFECTIVE DATE

The effective date of this contract shall be the date referenced on page 1 of this contract.

25) RESERVED

26) DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS rules and this contract.

Except as provided by 9 A.A.C. Chapter 28, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 22 and A.R.S.§36-2903.01. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

27) RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

28) INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

29) COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

30) CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 26, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

31) TYPE OF CONTRACT

Firm Fixed-Price

32) AMERICANS WITH DISABILITIES ACT

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting AHCCCS Administration.

33) WARRANTY OF SERVICES

The Contractor warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS's acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

34) NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

35) CONFLICT OF INTEREST

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS contractor, provider or Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

36) CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contrator shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to, 42 CFR 431.300 et seq., 45 CFR parts 160 and 164, and AHCCCS Regulation A.A.C. R9-22-512.

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

The Contractor shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

37) COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents, and carefully fit its own work to such other contractors' work. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees.

38) ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCS.

39) OWNERSHIP OF INFORMATION AND DATA

Any data or information system, including all software, documentation and manuals, developed by the Contractor pursuant to this contract, shall be deemed to be owned by AHCCCS. The Federal government reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal government purposes, such data or information system, software, documentation and manuals. Proprietary software which is provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership or licensing provisions of this section.

Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall be deemed to be owned by AHCCCS. The ownership provision is in consideration of the Contractor's use of public funds in collecting or preparing such data, information and reports. These items shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information. At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74 and 45 CFR Parts 6 and 8.

40) AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable AHCCCS Rule R9-22-521 and AHCCCS policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records. [42 CFR 438.6(g)]

At any time during the term of this contract, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts. [42 CFR 438.242(b)(3)]

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

41) LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds, other than those paid to the Contractor by AHCCCS, have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

42) CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

43) DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial data must be submitted concurrent with the data. Data certification must be submitted concurrently with the certified data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who report directly to the CEO or CFO [42 CFR 438.604.606.]

44) OFF SHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in the specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

45) FEDERAL IMMIGRATION AND NATIONALITY ACT

The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the contractor.

46) IRS W-9 FORM

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W-9 Form on file with the State of Arizona.

47) CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Contractor shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

[END OF SECTION E]

SECTION F: RESERVED

SECTION G: RESERVED

[END OF SECTION G]

SECTION H: RESERVED

[END OF SECTION H]

SECTION I: RESERVED

[END OF SECTION I]

SECTION J: LIST OF ATTACHMENTS

Attachment A: Minimum Subcontract Provisions
Attachment B: RESERVED
Attachment C: CRSA Financial Reporting Guide
Attachment D: RESERVED
Attachment E: RESERVED
Attachment F: Periodic Report Requirements
Attachment G: RESERVED
Attachment H: Grievance System and Standards
Attachment I: Performance Improvement Project Methodology
Attachment J: RESERVED
Attachment K: Cost Sharing Copayments

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

For the sole purpose of this Attachment, the following definitions apply:

"*Subcontract*" means any contract between the Contractor and a third party for the performance of any or all services or requirements specified under the Contractor's contract with AHCCCS.

"*Subcontractor*" means any third party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS.

All statutes, rules and regulations cited in this attachment are listed for reference purposes only and are not intended to be all inclusive.

[The following provisions must be included verbatim in every contract]

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Subcontractor under this subcontract may be assigned without the prior approval of the Contractor. No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from the Contractor. (AAC R2-7-305)

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or the Contractor may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or state employees. The Subontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee. (AAC R2-7-308)

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING

By signing this contract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services. (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361)

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements. (CLIA of 1988; 42 CFR 493, Subpart A)

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Contractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. If the Contractor is an inpatient facility, the Contractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS. [ARS 41-2548; 45 CFR 74.48 (d)]

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract**.** [42 CFR 434.70, 42 CFR 438.6(1)]

8. CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, ARS §36-107, 36-2932, 41-1959 and 46-135, AHCCCS Rules and Health Insurance Portability and Accountability Act (CFR 164).

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the AHCCCS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims shall be adjudicated in accordance with Department of Administration Rules and Contact disputes shall be adjudicated in accordance with AHCCCS Rules.

11. ENCOUNTER DATA REQUIREMENT

If the Subcontractor does not bill the Contractor (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to the Contractor in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCS, Office of Program Integrity. All incidents of potential fraud should be reported to AHCCCS, Office of the Director, Office of Program Integrity.

14. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the

parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

15. INSURANCE

[This provision applies only if the Subcontractor provides services directly to AHCCCS members]

The Subcontractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet Contractor's requirements. The Subcontractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Subcontractor, shall not limit the responsibility of Subcontractor to indemnify, keep and save harmless and defend the State and AHCCCS, their agents, officers and employees as provided herein. Furthermore, the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74) The requirement for Worker's Compensation Insurance does not apply if a Subcontractor is exempt under ARS 23-901, and when such Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state laws and regulations, the Subcontractor shall not bill, nor attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) was rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

18. NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, gender, national origin or disability. (Federal regulations, State Executive order # 99-4)

19. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies.

20. RECORDS RETENTION

The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and records shall be maintained to the extent and in such detail as required by AHCCCS Rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (45 CFR 74.53; 42 CFR 431.17; ARS 41-2548)

21. SEVERABILITY

If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

22. SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between the Contractor and AHCCCS for the provision of covered services.

23. TERMINATION OF SUBCONTRACT

AHCCCS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, AHCCCS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee. [AAC R2-5-501; ARS 41-2616 C.; 42 CFR 434.6, a.(6)]

24. VOIDABILITY OF SUBCONTRACT

This subcontract is voidable and subject to immediate termination by AHCCCS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without AHCCCS's prior written approval.

25. WARRANTY OF SERVICES

The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

26. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that

directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

27. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

ATTACHMENT B: RESERVED

ATTACHMENT C: CRSA FINANCIAL REPORTING GUIDE

STATE OF ARIZONA
CHILDREN'S REHABILITATIVE SERVICES (CRS)

Medicaid Managed Care Program

FINANCIAL REPORTING GUIDE

FOR

CRS Contractors

State of Arizona
Arizona Department of Health Services
Office of Children with Special Health Care Needs (OCSHCN)

Issue Date: January 2004

1.00 Purpose and Objective of the Guide

The purpose of the Financial Reporting Guide For CRS Contractors (Guide) is to set forth the quarterly and annual financial reporting requirements for CRS Contractors under contract with the Arizona Department of Health Services / CRS Administration (CRSA).

The primary objective of the Guide is to establish consistency and uniformity in financial reporting among CRS Contractors. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor's annual certified audit, nor to replace the independent certified public accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the independent certified public accountant on an annual basis and by the applicable CRS Contractor management on a quarterly basis.

1.01 Background

In July 2000, the Arizona Department of Health Services implemented a diagnosis based capitation rate system which provides coverage for CRS medical services for Title XIX and Title XXI eligible children under the age of 21 years old that have been determined to have a CRS eligible condition and are enrolled with a CRS Contractor. The goal of the managed care clinic-based delivery system is to administer innovative managed care programs effectively and efficiently, and continually improve accessibility and delivery of quality health care to eligible members through integrated health care systems.

1.02 Effective Dates and Reporting Time Frames

The provisions and requirements of this Guide are effective for calendar quarters beginning on and after January 1, 2004. As deemed necessary, amendments and/or updates to this Guide may be issued by the CRS Administration. CRS Contractors will be given the opportunity to submit their comments before changes are implemented.

Quarterly reporting is due within **45** days of each quarter end. A draft of the annual audited financial statements and management letter is not required, but is encouraged to be submitted within **90** days of the CRS Contractor's calendar year end. Final annual financial reports are due within **100** days of the CRS Contractor's calendar year end.

For selected reports, the CRS Contractor is required to follow a predetermined format for reporting enrollment and financial data.

The following table depicts the overall reporting requirements and scheduling.

Report #	Report Name	Frequency	Due Date [1]	Format
1	Enrollment	Quarterly	45 Days After Quarter End	Predetermined
2	Balance Sheet	Quarterly	45 Days After Quarter End	Predetermined
3	Analysis of Revenue and Expenses	Quarterly	45 Days After Quarter End	Predetermined
4	Claims Payable	Quarterly &	45 Days After	Predetermined

	(RBUCs and IBNRs)	Annual	Quarter End	
5	Claims Lag Report	Quarterly	45 Days After Quarter End	Predetermined
N/A	Footnotes	Quarterly	45 Days After Quarter End	Predetermined Minimums
N/A	Certification Statement	Quarterly	45 Days After Quarter End	Predetermined
N/A	Draft Annual Audit Report	Annual	90 Days After Year End	N/A
N/A	Draft Management Letter (Encouraged but not required)	Annual	90 Days After Year End	N/A
N/A	Final Annual Audit Report	Annual	100 Days After Year End	N/A
N/A	Final Management Letter	Annual	100 Days After Year End	N/A
N/A	Annual Reconciliation Report	Annual	100 Days After Year End	Suggested

[1] If a due date falls on a weekend or State recognized holiday, reports will be due the next business day.

2.00 General Instructions and Submission

The following are general instructions for completing the various quarterly reports required to be submitted by the CRS Contractor to the CRSA. The primary objective of these instructions is to promote uniformity in reporting and to ensure that the financial statements and reports are prepared in accordance with generally accepted accounting principles.

Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports.

All quarterly or annual reports must be completed and submitted to the CRSA within the due date. The CRSA may extend a report deadline if a request for an extension is communicated, in writing, and is received at least ten business days prior to the report deadlines. Request for extension must include the reason for the requested extension and the date by which the report will be filed.

The CRS Contractor must submit the forms on diskette or via e-mail. **A signed and dated Certification Statement is required for all quarterly report submissions.**

Each report submission (either on diskette or e-mail) should be accompanied by a printed copy for reference and verification. All reports should be addressed to the following person and address:

Cynthia Layne, Finance & Business Operations Manager
CRS Administration
150 North 18th Avenue, Suite 330

Phoenix, AZ 85007-3243

Phone: (602) 542-2879
Fax: (602) 542-2589
Email: cynthia.layne@azdhs.gov

Normally, line titles and columnar headings of the various reports are self-explanatory and therefore constitute instructions. However, specific instructions are provided for items that may have some question as to content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Always utilize predefined categories or classifications before reporting an amount as "OTHER". For any material amounts included in the "OTHER" category, **provide details and explanations**. For this purpose, **material** is defined as comprising an amount $\geq$ 5% of the total for each section. For example, if Other Income is reported that is less than 5% of Total Revenues, no disclosure is necessary. However, if Other Medical Expense is reported which equals 8% of Total Medical expenses, disclosure would be necessary. Disclosure, with detail explanation, should be prepared in a separate sheet accompanied with the report.

Unanswered questions and blank lines or schedules will not be considered properly completed. If no answers or entries are to be made, write "None", not applicable (N/A), or "-0-" in the space provided.

All amounts are to be reported in whole dollars only. The CRS Contractor may elect to report the amounts to the nearest whole dollar or through truncation of digits less than a dollar. (Examples: $504,932.65 may be reported as $504,933 by rounding or as $504,932 by truncation).

3.00 General Information – Quarterly Reporting

The following financial statements are to be reported on a quarterly basis. See Section 1.02 for the due dates of these reporting requirements.

- Certification Statement
- Enrollment (Report #1)
- Balance Sheet (Report #2)
- Analysis of Revenues and Expenses (Report #3)
- Claims Payable (RBUCs and IBNRs) (Report#4)
- Claims Lag Report (Report #5)
- Footnotes

3.01 Report #1 – Enrollment Table

Member Month Equivalents – These columns disclose member month equivalents per month by high, medium and low risk categories and for the state only category as shown on the report. A member month is equivalent to one member for whom capitation-based revenue has been recognized for the entire month. Where revenue is recognized for only part of a month for a given individual, a partial, pro-rated member month should be counted. A partial member month is pro-rated based on the actual number of days in a

particular month.

Year-to-Date (YTD) – The year-to-date column should equal the sum of as many months as have been completed through the quarter being reported. For example, after the first quarter, the year-to-date column will equal the first three months' numbers, but after the second quarter, the year-to-date column will equal the sum of the first six months.

3.02 Report #2 – Balance Sheet

CURRENT ASSETS are assets that are expected to be converted into cash or used or consumed within one year from the date of the balance sheet. Restricted assets for the general performance bond, contracts, reserves, etc., are not to be included as current assets.

Minimum Specification	Inclusion	Exclusion
Cash and Cash Equivalents	Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any cash (and equivalents) pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Short-term Investments	Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Accounts Receivable	Includes monies due the Contractor for services rendered for which payment has not yet been received	
Investment Income Receivable	Income earned but not yet received from cash equivalents, investments, performance bonds, and short and long-term investments.	
Other Current Assets	Include all other current assets not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for here. They should not be netted against the IBNRs. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	

CURRENT LIABILITIES are obligations whose liquidation is reasonably expected to occur within one year from the date of the balance sheet.

Minimum Specification	Inclusion	Exclusion
Accounts Payable	Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.	Amounts due to providers related to the delivery of health care services.
Accrued Administrative Expenses	Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.	
Medical Claims Payable (Detail in Report #4)	The total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs).	
Management Fee Payable to Parent Company	Includes all management services and/or corporate cost allocation plans. **Note, the CRSA reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If the fees or allocations actually paid out are determined to be unjustified or excessive, appropriate actions will be taken. Also, material amounts (greater than 5% of total liabilities) should be disclosed and fully explained in a separate sheet.**	
Other Current Liabilities (Specify)	Those current liabilities not specifically identified elsewhere. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	

EQUITY includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

Minimum Specification	Inclusion	Exclusion
Preferred Stock	Should equal the par value, or in the case of no-par shares, the stated or liquidation value, per share multiplied by the number of issued shares.	
Common Stock	Should equal the par value, or in the case of no-par shares, the stated value, per share multiplied by the number of issued shares.	
Additional Paid-in Capital	Amounts paid and contributed in excess of the par or stated value of shares issued.	
Contributed Capital	Capital donated to the CRS Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.	
Retained Earnings	The undistributed and unappropriated amount of earned surplus.	

3.03 **Report #3 – Analysis of Revenues and Expenses**

Report revenues and expenses using the full accrual method according to GAAP.

MEMBER MONTH EQUIVALENTS Automatic transfer of information from Report #1 – Enrollment Table.

REVENUES All revenues should be reported by rating category (Category of High, Medium, Low, State Only, and other).

Minimum Specification	**Inclusion**	**Exclusion**
Capitation Revenue	Revenue recognized on a prepaid basis for provision of covered services.	
Investment Income	All investment income earned during the period.	Do **not** net interest income and interest expense together.
Fixed fee – State only	All State only income earned during the period	
Other Income (Specify)	Revenue from sources not identified in the other revenue categories. **Note, material amounts (greater than 5% of total revenues) should be disclosed and fully explained in a separate sheet.**	

MEDICAL EXPENSES All medical expenses must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
Hospital Inpatient – In State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital, including out of area (OOA) hospitalization.	Do not include inpatient costs provided in an out of state facility.
Hospital Outpatient – In State	The facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include outpatient costs provided in an out of state facility.
Hospital Inpatient / Out patient – Out of State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital. Also include the facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include inpatient or outpatient costs that were provided in state.
Physician – Regional Clinic	All costs associated with medical services provided by a physician or other practitioner in a regional clinic including only non-salaried physicians and other non-salaried practitioners that are compensated	Do not include any physician costs for salaried physicians or salaried other practitioners

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
	on a fee for service, hourly, session rate basis or comparable basis.	
Physician – Outreach Clinic	All costs associated with medical services provided by a physician in an outreach clinic including only non-salaried physicians and other non-salaried practitioners that are compensated on a fee for service, hourly, session rate basis or comparable basis.	Do not include any physician costs for salaried physicians or salaried other practitioners
Physician – Non Clinics	All costs associated with medical services provided by a physician or other practitioner in a setting other than a regional or outreach clinic.	Do not include physician costs provided in a regional or outreach clinic setting. or salaried physicians or other practitioners
Clinic – Professional Staff (Salaried)	All costs (including payroll taxes) associated with medical services provided by physicians, other practitioners, and medical personnel in a regional clinic including only salaried personnel.	Exclude costs for physician, other practitioner, and other medical staff that are not considered part of the CRS Contractor staff.
Medical Support Administration - Clinics	All other costs related to the provision of medical services within a regional or outreach clinic. Costs should include allocation of rent, depreciation, telephone, and other utilities.	Non-Clinic Administration
Medical Supplies and Other Costs - Clinics	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach clinic setting.	
Pharmacy	Expenses for drugs provided that include both ingredient costs and dispensing fees. Also include any clinical staffing and related administrative pharmacy costs.	
Durable Medical Equipment	The cost of durable medical equipment (DME).	
All Other Medical	All other medical costs not related to any of the above categories of service.	

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
Non Covered Services	All costs for services not specifically identified as a CRS covered Service	

REINSURANCE and THIRD PARTY LIABILITY All reinsurance and third party liability recoveries must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Reinsurance	All reinsurance expected to be recovered from the State or reinsurance company under a reinsurance agreement.	
Third Party Liability	Cost sharing revenue, including third party sources.	

ADMINISTRATION All administrative costs must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Administrative Compensation	All costs (including payroll taxes) associated with non-clinical administrative services provided by personnel in a regional or outreach clinic.	Administration - Exclude Administrative Fees owed to Parent Company
Interest expenses	Interest expenses	Do **not** net interest income and interest expense together.
Occupancy, Depreciation & Amortization	Occupancy, Depreciation & Amortization costs related to services provided in a regional or outreach clinic	
Administrative Allocations from Affiliate/Parent	Administrative costs allocated to the CRS Contractor for the current period by a parent or affiliate management company.	

3.04 Report #4 – Medical Claims Payable (RBUCs and IBNRs)

Reported but unpaid claims (RBUCs) are to be reported by the appropriate expense categories. A claim becomes an RBUC the day it is received by the CRS Contractor, not the day it is processed/adjudicated. The incurred but not reported (IBNR) claims should be reported in the second to last column by the appropriate category.

3.05 Report #5 – Claims Lag Reports

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. The following information is provided as guidelines to help make this analysis (also see Appendix C).

Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. All CRS Contractors should use lag information as a validation test for accruals calculated using other methods, if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid by the CRS Contractor on the other axis (vertical). Remember, it is best to track specific information by population risk group and by category of service, as each population may have different characteristics.

Once a number of months becomes "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are submitted historically and applying this information to months which are not yet fully developed.

Although not currently required, a separate table could be completed for the following categories of service:

1) Hospital
2) Physician
3) All Other

Claims Lag Table Example

The following simple example demonstrates the lag table approach discussed above.

Fully Developed Table

	Month Incurred (Date of Service)					
Month Paid	January	February	March	Total	Percent of Total	Cumulative Percent
Current	$ 1,400	$ 800	$ 2,000	$ 4,200	10.0%	10.0%
1st Prior	$ 8,200	$ 8,750	$ 8,500	$25,450	60.6%	70.6%
2nd Prior	$ 3,700	$ 2,800	$ 3,750	$10,250	24.4%	95.0%
3rd Prior	$ 700	$ 650	$ 750	$ 2,100	5.0%	100.0%
TOTAL	$14,000	$13,000	$15,000	$42,000	100.0%	

This table indicates that 10% of all claims are reported and paid in the month services are rendered; in the next month, 60.6% of the claims are paid; and so on. In this example, all

claims are shown to be paid within four months from the date of service (i.e., fully developed). This may be unrealistic but it satisfies the needs of this example. The above information can be used to calculate IBNRs by looking at claims payment experience for the three months prior to the balance sheet date.

By dividing claim payments to date by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate is made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims expense accrual.

The following steps must be taken:

In order to estimate the total claims expense as of the end of June,

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.

2. Subtract all claims already paid or received (RBUC's) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

	Month Incurred			
Month Paid	April	May	June	Total
Current	$ 1,600	$ 1,900	$1,600	$ 5,100
1st Subsequent	$ 9,700	$10,600	$ ------	$20,300
2nd Subsequent	$ 3,800	$ -------	$ ------	$ 3,800
3rd Subsequent	$--------	$ -------	$ ------	$ -------
TOTAL	$15,100	$12,500	$1,600	$29,200
Divided by Cumulative Percent Paid	95.0%	70.6%	10.0%	N/A
Estimated Total Claims Expense	$15,895	$17,705	$16,000	$49,600
Less: Amount Paid to Date	(15,100)	(12,500)	(1,600)	(29,200)
Less: RBUC's	(100)	(200)	(1,100)	(1,400)
Estimated Claims Accrual (IBNR)	$695	$5,005	$13,300	$19,000

It should be noted that the estimates developed by this lag technique should be monitored for reasonableness. This is especially true for the most recent months where the information is less developed than the older months. If the calculation is producing an unusually low or high total claims expense for any particular month it should be investigated for validity. An example of a possible solution is to override the skewed portion of the IBNR with an average monthly cost less the amount paid to date for that month.

3.06 Footnotes

The Contractor shall prepare footnote disclosures to accompany each set of quarterly financial reports. The footnotes should provide sufficient detail and complete disclosure of significant accounting assumptions, estimates, and changes in financial condition and significant ownership/control relationships.

In addition, the Contractor shall report the pricing methodology utilized to determine medical expenditures for the period. This shall be done at the same level of detail as is required for medical expenditures in Report #3 – Analysis of Revenues and Expenses. If multiple pricing schemes are utilized by the Contractor for a particular category of service, disclose the most prevalent approaches utilized (based on total expenditures). For example, if the Contractor reimburses inpatient hospital service providers using a percentage of billed charges approach for affiliated entities and out-of-state hospitals, and the AHCCCS tiered per-diem schedule for unaffiliated hospitals in state, both should be disclosed, along with the percent of billed charges paid to affiliates and non affiliated providers. The table below should be utilized for these disclosures.

Sample Disclosure Table

Categories of Service	**Method of Reimbursement/Basis of Expense Recognition**	**Approximate Percentage of Expenditures**
Hospital Inpatient – In State	1) Affiliated Hospitals – Percentage of billed charges (60%) 2) Non-Affiliated Hospitals – AHCCCS Tiered Per Diem	1) 95% 2) 5%
Hospital Outpatient – In State	1) Affiliated Hospitals – Percentage of billed charges (55%) 2) Non-Affiliated Hospitals – AHCCCS cost-to-charge ratio	1) 90% 2) 10%
Hospital Inpatient / Out patient – Out of State	1) Percentage of billed charges (varies by contract) 2) Negotiated rate per patient	1) 60% 2) 40%
Physician – Regional Clinic	1) Physicians – Percent of Billed Charges (80%) 2) Physicians – Percent of AHCCCS FFS rates (95%) 3) Non-Physicians – Hourly rate (per contract)	1) 40% 2) 30% 3) 30%
Physician – Outreach Clinic	1) Physicians – Percent of Billed Charges (850%) 2) Physicians – Percent of AHCCCS FFS rates (100%) 3) Non-Physicians – Hourly rate (per contract)	1) 60% 2) 10% 3) 30%
Physician –	1) Physicians – Percent of Billed	1) 20%

Categories of Service	**Method of Reimbursement/Basis of Expense Recognition**	**Approximate Percentage of Expenditures**
Non Clinics	Charges (70%) 2) Physicians – Percent of AHCCCS FFS rates (105%) 3) Non-Physicians – Hourly rate (per contract)	2) 65% 3) 15%
Clinic – Professional Staff (Salaried)		
Medical Support Administration - Clinics		
Medical Supplies and Other Costs - Clinics	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach clinic setting.	
Pharmacy	Discount - AWP less 15% Dispensing Fee - $2.75 Administration Fee – Not applicable	100% 100%
Durable Medical Equipment	AHCCCS FFS Fee Schedule	100%
All Other Medical		
Non Covered Services		

4.00 General Information – Annual Reporting

The CRS Contractor is required to submit certain financial reports and schedules to the CRSA on an annual basis. See Section 1.02 for the due dates of the annual reporting requirements.

The annual financial reports and schedules must disclose the CRS line of business (including assets, liabilities, equity, revenue, and expenses) independent of any other line of business in which the CRS Contractor may be engaged.

For example, if a CRS Contractor also has a contract to provide services not related to its CRS Contract with ADHS, the financial statements must at least separate these lines of business in the form of additional supplemental schedules, if they are not separately presented in the financial statements themselves. In addition, **all required supplemental schedules listed in Section 4 are to represent the CRS line of business exclusively.**

4.01 Required Statements and Supplemental Schedules

The following statements and schedules must be included in the audited financial statements accompanied by an independent certified public accountant's report thereon.

- Balance Sheet
- Statement of Revenues and Expenses and Changes in Equity/Net Assets
- Footnotes

Other required, supplemental schedules include:

- Claims Payable (See Report #4)
- Final Management Letter
- Annual Reconciliation Report

4.02 Annual Reconciliation Report

In addition to the annual audited financial statements, a reconciliation of the CRS Contractor's final year-to-date quarterly financial statements to the annual audited statements must be submitted with the final audited statements. (See Appendix B for example)

5.00 Glossary of Terms

CAPITATION. A fixed premium that is paid per eligible member periodically (usually monthly) to a contractor or subcontractor as compensation for providing health care services for the period.

CRS CONTRACTOR. Organization or entity agreeing through a direct contracting relationship with the ADHS/CRS Administration to provide those goods and services specified by contract.

DAY. Day means calendar day unless otherwise specified.

ENROLLMENT. Process by which a person who has been determined eligible becomes qualified to receive CRS covered services from a CRS Contractor.

FEE-FOR-SERVICE. Payment mechanism by which contractors, subcontractors and other providers of care are reimbursed upon submission of valid claims for specific covered services and equipment provided to eligible persons.

INCURRED BUT NOT REPORTED CLAIMS (IBNRs). The liability for services rendered for which claims have not been received.

INPATIENT. A patient who is provided with room, board, and general nursing service in a hospital setting and is expected to remain at least overnight and occupy a bed.

OUTPATIENT. A patient who is not confined overnight in a health care institution.

PHARMACY. Establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist.

PROVIDER. A person or entity that undertakes to provide health care services.

RELATED PARTY TRANSACTIONS. Transactions, whether or not in the ordinary course of business, with directors, management, medical staff, or other related parties.

REPORTED BUT UNPAID CLAIMS (RBUCs). A claim is considered received the day it is physically received at the CRS Contractor.

THIRD PARTY. An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

6.0 Appendices

(A) Quarterly Certification Statement
(B) Reconciliation - Annual Audit and CRS Contractor Year End Quarterly Financial Statements
(C) Medical Claims Payable (RBUCs and IBNRs) General Information

[END OF ATTACHMENT]

ATTACHMENT D: RESERVED

ATTACHMENT E: RESERVED

ATTACHMENT F: PERIODIC REPORT REQUIREMENTS

The following table is a summary of the reporting requirements for CRSA and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit CRSA's responsibilities in any manner.

Annual Reports

Report	Reporting Period	Due Date	AHCCCS Contact
Written Description of Covered Services (Sec. D., ¶10, Scope of Services)	Annual	October 1	DHCM, Acute Care Operations
Medical Eligibility Criteria Policy (Sec. D., ¶2, Eligibility for Services)	Annual	October 1, and upon revision	DHCM, Acute Care Operations
Delegation Contact List (Sec. D., ¶16 Staff Requirements and Support Services)	Annual	October 1, within 7 days of a change in contact information	DHCM, Acute Care Operations
Business Continuity and Recovery Plan Summary (Business Continuity and Recovery Plan Policy)	Annual	October 15	DHCM, Acute Care Operations
Cultural Competency Plan and Assessment of Effectiveness (Sec. D., ¶20, Cultural Competency)	Annual	November 14	DHCM, Acute Care Operations
Provider Network Development and Management Plan (Sec. D., ¶29, Network Management)	Annual	November14	DHCM, Acute Care Operations
CRSA's Organizational chart and related documents (Sec. D., ¶16, Staff Requirements and Support Services)	Annual	November 31	DHCM, Acute Care Operations
Recipient Handbook (Sec. D., ¶9, Recipient Information)	NA	August 15th	DHCM, Acute Care Operations
Delegation Report (Sec. D. ¶37, CRSA Subcontracts)	Annual	December1	DHCM, Acute Care Operations
Recipient Survey Tool, Sample, Distribution Methodology and Timeline (Sec. D., ¶19, Survey)	Annual	90 days prior to the intended start	DHCM, Acute Care Operations
Recipient Survey Results and Analysis (Sec. D., ¶19, Survey)	Annual	Within 45 days of the completion	DHCM, Acute Care Operations

Report	Reporting Period	Due Date	AHCCCS Contact
Performance Review and the Corrective Action Plan of CRSA Subcontractors (Sec. D, ¶37, CRSA Subcontracts)	Annual	Upon completion	DHCM, Acute Care Operations
Draft Annual Audit Report (Sec. D., ¶44, Financial Operations)	Prior contract year	90 days after end of fiscal year	DHCM, Financial Manager
Draft Management Letter (Sec. D., ¶44, Financial Operations)	Prior contract year	90 days after end of fiscal year	DHCM, Financial Manager
Final Annual Audit Report (Sec. D., ¶44, Financial Operations)	Prior contract year	120 days after end of fiscal year	DHCM, Financial Manager
Final Management Letter (Sec. D., ¶44, Financial Operations)	Prior contract year	120 days after end of fiscal year	DHCM, Financial Manager
Accountant's Report on Compliance (Sec. D., ¶44, Financial Operations)	Prior contract year	120 days after end of fiscal year	DHCM, Financial Manager
Reconciliation – Annual Audit and Plan Year-to-Date Financial Report Information (Sec. D., ¶44, Financial Operations)	Prior contract year	90 and 120 days after the fiscal year	DHCM, Financial Manager
Financial Disclosure Report (Sec. D., ¶44, Financial Operations)	Prior contract year	120 days after end of fiscal year	DHCM, Financial Manager
Performance Improvement Project Proposal (Initial/baseline year of the project) (Sec. D., ¶23, Quality Management)	Annual	December 15	DHCM, CQM
Performance Improvement Project Re-measurement Report (Sec. D., ¶23, Quality Management)	Annual	December 15	DHCM, CQM
Performance Improvement Project Final Report (Sec. D., ¶23, Quality Management)	Annual	December 15	DHCM, CQM
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with Document)	Annual	December 15	DHCM, CQM
Proposed Capitation Rates (Sec. D., ¶53, Compensation)	Annual	July 1	DHCM, Financial Manager

Quarterly Reports

Report	Reporting Period	Due Date	AHCCCS Contact
Quarterly QM Report	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	30 days after the end of each quarter	DHCM, CQM
Quarterly UM Report	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, Medical Management
Quarterly Inpatient Hospital Showing	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, Medical Management
Quarterly Financial Report (Sec. D., ¶21, Financial Operations)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	75 days after the end of the quarter	DHCM, Financial Manager
Certification Statement (Sec. D., ¶21, Financial Operations)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 30 April 1 – June 30	75 days after the end of the quarter	DHCM, Financial Manager

Monthly Reports

Report	Due Date	AHCCCS Contact
Corrected Pended Encounter Data (Attachment E, Encounter Submission Requirements)	Monthly according to established schedule	DHCM, Encounter Administrator
New Day Encounter (Attachment E, Encounter Submission Requirements)	Monthly according to established schedule	DHCM, Encounter Administrator
Claims Dashboard	15th day of each month following the reporting period	DHCM, Operations & Compliance Officer
Administrative Measures	15th day of each month following the reporting period	DHCM, Operations & Compliance Officer
Grievance System Report	See Grievance System Reporting Guide for frequency	DHCM, Operations & Compliance Officer
Enrollee Grievance Report	See Grievance System Reporting Guide for frequency	DHCM, Operations & Compliance Officer

Ad Hoc Reports

Report	Due Date	AHCCCS Contact
Changes in CRSA Key Staff (Sec. D., ¶11, Staff Requirements and Support Services)	Within 7 days of change	DHCM, Acute Care Operations
CRSA Subcontracts (Sec. D., ¶37, CRSA Subcontracts)	At least 30 days prior to the beginning date of the contract	DHCM, Acute Care Operations
Network Impairment Notice (Sec. D., ¶29, Network Management)	Within 1 day of awareness	DHCM, Acute Care Operations

Report	Due Date	AHCCCS Contact
Subcontractor Non-Compliance and the Corrective Measures Taken (Sec. D. ¶37, CRSA Subcontracts and Subcontractor Management)	Within 5 working days of any action taken	DHCM, Acute Care Operations
Eligible Person Fraud/Abuse Report (Sec. D., ¶62, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
Provider Fraud/Abuse Report (Sec. D., ¶62, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
Medical Records for Data Validation (Sec. D., ¶66 Encounter Data Reporting)	90 days after the request received from AHCCCS	DHCM, Encounter Administrator
Third Party Change Form (Sec. D., ¶58, Coordination of Benefits)	Within 10 days of discovery	Division of Member Services
CRSA Administrative Cost Report (Sec. D., ¶53, Compensation)	July to December due on March 31 January to June due on September 30	DHCM, Financial Manager

[END OF ATTACHMENT]

ATTACHMENT G: RESERVED

ATTACHMENT H(1): ENROLLEE GRIEVANCE SYSTEM STANDARD AND POLICY

CRSA or its subcontractors shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. CRSA or its subcontractors shall provide the ACOM *Enrollee Grievance Policy* to all providers and subcontractors at the time of contract. CRSA or its subcontractors shall also furnish this information to CRS recipients within a reasonable time after CRSA or its subcontractors receive notice of the CRS recipient's enrollment. Additionally, CRSA or its subcontractors shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to CRS recipients describing the Grievance System including the grievance process, the appeals process, CRS recipient rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the subcontractor's service area and in an easily understood language and format. CRSA or its subcontractors shall inform CRS recipients that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how CRS recipients may obtain this information.

CRSA and its subcontractors shall comply with AHCCCS Contractor Operations Manual (ACOM) Policy 409 "Notices of Action" which sets forth the circumstances when the ALTCS/Acute Care Contractor is responsible for evaluating a request for service authorization and issuing a Notice of Action for AHCCCS members. CRSA and its subcontractors are responsible for evaluating a request for service authorization, issuing a Notice of Action, and complying with the pertinent standards below when the AHCCCS member is CRS eligible, the member initiates the service request with CRSA or its subcontractors, and the service request falls within the scope of a CRS covered service. CRSA and its subcontractors are also responsible for issuing a Notice of Action and complying with the pertinent standards below when CRSA or its subcontractors limit, reduce, or terminate a service which has been previously authorized.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be translated in the recipient's language if information is received by CRSA or its subcontractor, orally or in writing, indicating that the recipient has a limited English proficiency. Otherwise, these documents shall be translated in the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the CRS recipient that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how CRS recipients may obtain this information. This information must be in large, bold print appearing in a prominent location on the first page of the document.

At a minimum, the CRSA Grievance System Standards and Policy shall specify:

1. That CRSA or its subcontractors shall maintain records of all grievances and appeals and request for hearing.

2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal.

3. The availability of assistance in the filing process and CRSA or its subcontractors' toll-free numbers

that a CRS recipient can use to file a grievance or appeal by phone if requested by the CRS recipient.

4. That CRSA or its subcontractors shall acknowledge receipt of each grievance and appeal. For Appeals, CRSA or its subcontractors shall acknowledge receipt of standard appeals in writing within five working days of receipt and within one working day of receipt of expedited appeals.

5. That CRSA or its subcontractors shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

6. That CRSA or its subcontractors shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the CRS recipient's condition or disease.

7. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 calendar days if the CRS recipient requests the extension or if CRSA or its subcontractors establishes a need for additional information and that the delay is in the CRS recipient's interest.

8. That if CRSA or its subcontractors extends the timeframe for resolution of an appeal when not requested by the CRS recipient, CRSA or its subcontractors shall provide the CRS recipient with written notice of the reason for the delay.

9. The definition of grievance as a CRS recipient's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.

10. That a CRS recipient must file a grievance with CRSA or its subcontractors and that the CRS recipient is not permitted to file a grievance directly with AHCCCS Administration..

11. That CRSA or its subcontractors must dispose of each grievance in accordance with the ACOM, *Enrollee Grievance Policy*, but in no case shall the timeframe exceed 90 days.

12. The definition of action as the [42 CFR 438.400(b)]:
    a. Denial or limited authorization of a requested service, including the type or level of service;
    b. Reduction, suspension, or termination of a previously authorized service;
    c. Denial, in whole or in part, of payment for a service;
    d. Failure to provide services in a timely manner;
    e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
    f. Denial of a rural CRS recipient's request to obtain services outside CRSA or its subcontractors' network under 42 CFR 438.52(b)(2)(ii), when CRSA or its subcontractors is the only Contractor in the rural area.

13. The definition of a service authorization request as a CRS recipient's request for the provision of a service [42 CFR 431.201].

14. The definition of appeal as the request for review of an action, as defined above.

15. Information explaining that a provider acting on behalf of a CRS recipient and with the CRS recipient's written consent, may file an appeal.

16. That a CRS recipient may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of CRSA or its subcontractors to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural CRS recipient's request to obtain services outside the CRS network under 42 CFR 438.52(b)(2)(ii) when CRS is the only contractor in the rural area.

17. The definition of a standard authorization request. That for standard authorization decisions, CRSA or its subcontractors must provide a Notice of Action to the CRS recipient as expeditiously as the CRS recipient's health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the CRS recipient or provider requests an extension or if CRSA or its subcontractors establishes a need for additional information and delay is in the CRS recipient's best interest. [42 CFR 438.210(d)(1)] The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

18. The definition of an expedited authorization request. For expedited authorization decisions, CRSA or its subcontractors must provide a Notice of Action to the CRS recipient as expeditiously as the CRS recipient's health condition requires, but not later than 3 business days following the receipt of the authorization request with a possible extension of up to 14 days if the CRS recipient or provider requests an extension or if CRSA or its subcontractors establishes a need for additional information and delay is in the CRS recipient's interest. [42 CFR 438.210(d)(2)]

19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If CRSA or its subcontractors extends the timeframe to make a standard or expedited authorization decision, CRSA or its subcontractors must give the CRS recipient written notice of the reason to extend the timeframe and inform the CRS recipient of the right to file a grievance if the CRS recipient disagrees with the decision. CRSA or its subcontractors must issue and carry out its decision as expeditiously as the CRS recipient's health condition requires and no later than the date the extension expires.

20. That CRSA or its subcontractors shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.

21. The definition of a standard appeal and that CRSA or its subcontractors shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

22. The definition of an expedited appeal and that CRSA or its subcontractors shall resolve all expedited appeals not later than three business days from the date CRSA or its subcontractors receives the appeal (unless an extension is in effect) where CRSA or its subcontractors determines (for a request from the CRS recipient), or the provider (in making the request on the CRS recipient's behalf indicates) that the standard resolution timeframe could seriously jeopardize the CRS recipient's life or

health or ability to attain, maintain or regain maximum function. CRSA or its subcontractors shall make reasonable efforts to provide oral notice to a CRS recipient regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

23. That if CRSA or its subcontractors denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. CRSA or its subcontractors must make reasonable efforts to give the CRS recipient prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.

24. That a CRS recipient shall be given 60 days from the date of CRSA or its subcontractors' Notice of Action to file an appeal.

25. That CRSA or its subcontractors shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 5 days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a request for a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, CRSA or its subcontractor shall also ensure that the Notice of Action provides the recipient with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, CRSA or its subcontractor may elect to mail a Notice of Action no later than the date of action when:
    a. CRSA or its subcontractor receives notification of the death of a CRS recipient;
    b. The CRS recipient signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
    c. The CRS recipient is admitted to an institution where he/she is ineligible for further services;
    d. The CRS recipient's address is unknown and mail directed to the CRS recipient has no forwarding address;
    e. The CRS recipient has been accepted for Medicaid in another local jurisdiction.

26. That CRSA or its subcontractors include, as parties to the appeal, the CRS recipient, the CRS recipient's legal representative, or the legal representative of a deceased CRS recipient's estate.

27. That the Notice of Action must explain: 1) the action CRSA or its subcontractors has taken or intends to take, 2) the reasons for the action, 3) the CRS recipient's right to file an appeal with CRSA or its subcontractors, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the CRS recipient's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the CRS recipient may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.

28. That benefits shall continue until a hearing decision is rendered if: 1) the CRS recipient files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the CRSA or its subcontractors' action, 2) a. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment, or b. the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously

authorized service, 3) the services were ordered by an authorized provider, and 4)) the CRS recipient requests a continuation of benefits.

For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction, or suspension which has been appealed.

29. That for appeals, CRSA or its subcontractors provides the CRS recipient a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that CRSA or its subcontractors informs the CRS recipient of the limited time available in cases involving expedited resolution.

30. That for appeals, CRSA or its subcontractors provides the CRS recipient and his/her representative the opportunity before and during the appeals process to examine the CRS recipient's case file including medical records and other documents considered during the appeals process.

31. That CRSA or its subcontractors must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a CRS recipient's appeal.

32. That CRSA or its subcontractors shall provide written Notice of Appeal Resolution to the CRS recipient and the CRS recipient's representative or the representative of the deceased CRS recipient's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of CRS recipients: a) the CRS recipient's right to request a State fair hearing (including the requirement that the recipient must file the request for a hearing in writing) no later than 30 days after the date the recipient receives CRSA or its subcontractors' notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the CRS recipient may be held liable for the cost of benefits if the hearing decision upholds CRSA or its subcontractor.

33. That CRSA or its subcontractor continues extended benefits originally provided to the CRS recipient until any of the following occurs: 1) the CRS recipient withdraws appeal, 2) the CRS recipient has not specifically requested continued benefits pending a hearing decision within 10 days of CRSA or its subcontractors mailing of the appeal resolution notice, or 3) the AHCCCS Administration issues a state fair hearing decision adverse to the CRS recipient. .

34. That if the CRS recipient files a request for hearing CRSA or its subcontractors must ensure that the case file and all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by CRSA or its subcontractors must contain a cover letter that includes:
    a. CRS recipient's name;
    b. CRS recipient's AHCCCS I.D. number;
    c. CRS recipient's address;
    d. CRS recipient's phone number (if applicable);
    e. Date of receipt of the appeal; and,
    f. Summary of CRSA or its subcontractors' actions undertaken to resolve the appeal and summary of the appeal resolution.

35. The following material shall be included in the file sent by CRSA or its subcontractors:
    a. The CRS recipient's written request for hearing;
    b. Copies of the entire appeal file which includes all supporting documentation including

pertinent findings and medical records;
c. CRSA or its subcontractors' Notice of Appeal Resolution; and,
d. Other information relevant to the resolution of the appeal.

36. That if CRSA or its subcontractors or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal was or the pendency of the hearing process, CRSA or its subcontractors shall authorize or provide the services promptly and as expeditiously as the CRS recipient's health condition requires irrespective of whether CRSA or its subcontractor contests the decision.

37. That if CRSA or its subcontractors or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, CRSA or its subcontractors shall pay for those services, as specified in policy and/or regulation.

38. If the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

39. That if CRSA or its subcontractors or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, CRSA or its subcontractors may recover the cost of those services from the CRS recipient.

ATTACHMENT H(2): PROVIDER CLAIM DISPUTE STANDARDS AND POLICY

CRSA or its subcontractors shall have in place a written claim dispute policy for providers.. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claim dispute policy shall include the following provisions:

1. The Provider Claim Dispute policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.

2. The Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments, must be filed with CRSA or its subcontractors no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.

4. A log is maintained for all claim disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claim dispute and the date the claim dispute is resolved. Separate logs must be maintained for provider and CRS recipient claim dispute.

5. Within five business days of receipt, the Complainant is informed by letter that the claim dispute has been received.

6. Each claim dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.

7. All documentation received by CRSA or its subcontractors during the claim dispute process is dated upon receipt.

8. All claim disputes are filed in a secure designated area and are retained for five years following the CRSA or its subcontractors' decision, the Administration's decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.

9. A copy of CRSA or its subcontractors' Notice of Decision (hereafter referred to as Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:

    a. the nature of the claim dispute
    b. the issues involved
    c. the reasons supporting CRSA or its subcontractors' Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
    d. the Provider's right to request a hearing by filing a written request for hearing to CRSA or its subcontractors no later than 30 days after the date the Provider receives CRSA or its subcontractors' decision.

e. If the claim dispute is overturned, the requirement that CRSA or its subcontractors shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

10. If the Provider files a written request for hearing, CRSA or its subcontractors must ensure that all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS), no later than five business days from the date CRSA or its subcontractor receives the provider's written hearing request . The file sent by CRSA or its subcontractor must contain a cover letter that includes:

    a. Provider's name
    b. Provider's AHCCCS ID number
    c. Provider's address
    d. Provider's phone number (if applicable)
    e. the date of receipt of claim dispute
    f. a summary of CRSA or its subcontractor' actions undertaken to resolve the claim dispute and basis of the determination

11. The following material shall be included in the file sent by CRSA or its subcontractor:

    a. written request for hearing filed by the Provider
    b. copies of the entire file which includes pertinent records; and CRSA or its subcontractor' Decision
    c. other information relevant to the Notice of Decision of the claim dispute

12. If CRSA or its subcontractor' Decision regarding a claim dispute is reversed through the appeal process, CRSA or its subcontractors shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

ATTACHMENT I: PERFORMANCE IMPROVEMENT PROJECT METHODOLOGY

Project Title: **Improving Pediatric-to-Adult Transition Services**

Background: Transition, as defined in a position paper from the Society for Adolescent Medicine, is "the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from a child-centered to adult-oriented health care system." The position paper also promotes transition as an important component of high-quality health care.[1] Further, the Maternal and Child Health Bureau (MCHB) has identified transition as one of six core outcomes that, when achieved, will indicate successful progress toward the goal of a community-based system of services for children with special health care needs.[2]

In recent years, more and more youth with chronic conditions are surviving into adulthood. Each year, in the United States, nearly half a million children with special health care needs cross the threshold into adulthood.[3] One generation ago, most of those with severe disabilities died before reaching maturity; now more than 90% survive to adulthood.[4] Thus, transition planning has become even more important as a health care quality issue.

Transition planning is a complex process that needs to be individualized for each young adult and requires coordination with health care providers, family members, and all involved in the care of the young adult. Optimum transition plans include steps to assure that young adults will become independent, functioning adults in all aspects of their lives. Transition planning and services are components of the Medical Home model promoted by the American Academy of Pediatrics (AAP). Additionally, transition services and a plan are required for youth who receive services through the Individuals with Disabilities Education Act (IDEA) in their Individualized Educational Plan (IEP). This plan is required at age 14 years.

Given the national focus on transition issues and the designation of transition as a core outcome measure for children with special health care needs, the Arizona Department of Health Services (ADHS) Children's Rehabilitative Services (CRS) recently implemented contractual requirements for transition activities. CRS contracts now require that transition services are initiated at age 14 years, are ongoing until exit from the CRS program, and are documented in the medical records of transitioning youth. The contract language regarding transition was developed based on the age at which the IEP plan addresses transition, and on lessons learned from MCHB's Healthy and Ready to Work (HRTW) grant initiatives funded from 1996 to 2001.[5]

Per AHCCCS Medical Policy, ADHS/CRS carefully considered information from all potential sources in the selection and development of a Performance Improvement Project. Transition planning was identified as an area of concern. A presentation about Performance Improvement Project selection was given at a CRS Medical Directors/Administrators meeting in April of 2004. A survey of CRS Medical Directors and Administrators following the presentation identified transition planning as one suggested Performance Improvement Project. Transition as a potential project was discussed with OCSHCN Section Managers, the Quality Management section, and the Data, Planning, and Evaluation section. Additional support for transition as a performance improvement project was obtained via informal communications from CRS providers, health care providers in the community, and parents, who expressed that there is a need for improving the transition process for youth. Communications within the last year between the ADHS/CRS Medical Director and AHCCCS health plans support the need for improvement in transition processes. Additionally, the AHCCCS/CRS Taskforce felt that transition was an important need and developed a transition checklist tool as an attempt to improve processes for transitioning youth.

Although family satisfaction with transition services is measured in the State and Local Area Integrated Telephone Survey (SLAITS), conducted on the national level, the most recent data from 2001 did not meet reliability and validity standards and thus, does not provide useful information on transition. The 2002 ADHS/CRS Family Centered Survey is one source of data available on family satisfaction regarding transition. Families were asked to identify priority areas for improvement in CRS. Help with transition to adulthood was ranked the third highest area in need of improvement. Anecdotally, we have been made aware via communications with parents and youth that transition planning is important, and that several barriers exist that limit effective transition.

Purpose: The purpose of this project is to improve transition services for youth enrolled in the Children's Rehabilitative Services program, with the overall goal of improving successful transition to adulthood. Providing transition planning allows young people to optimize their ability to assume adult roles and functioning. Starting the transition process early in adolescence gives youth and their families time to plan and to address the many complex issues involved in transition. The project will measure whether transition planning is initiated and documented for youth enrolled in CRS, as is required by contractual agreement. Results will be analyzed and interventions developed to address the barriers to providing transition services.

Study Questions: What percent of members within the measurement period(s) have a transition plan initiated and documented in the medical record by their 15th birthdays?
How do the percentages compare by CRS contractor site?

Measurement Periods: Baseline Measurement – July 1, 2003, through June 30, 2004
First Remeasurement – July 1, 2005, through June 30, 2006
Second Remeasurement – July 1, 2006, through June 30, 2007

Population: CRS enrolled members who were concurrently enrolled in AHCCCS (Medicaid) or KidsCare.

Population Stratification: Members will be stratified by CRS subontractor site.

Population Exclusions: Members who were not continuously enrolled in CRS for 12 months prior to and including their 15th birthdays.

CRS members who were not concurrently enrolled in AHCCCS during the measurement period.

Population Sample Frame: CRS members enrolled in AHCCCS or KidsCare who turned 15 years of age, during the measurement period and were continuously enrolled for 12 months prior to and including their 15th birthdays.

Sample Selection: CRS will select a representative, random sample of members, stratified by subontractor, using a 95-percent confidence level and an error tolerance of +/-5 percent.

Note: If sampling yields insufficient numbers to conduct analysis for any subontractor site, all members in the sample frame for that site will be selected.

Indicator Descriptions: The percent of enrolled members with a documented transition plan initiated by their 15th birthdays.

Indicator Documentation must include the date on which a transition plan was initiated, and must be in the

Criteria: member's medical record. The planning process may take place via telephone call or by patient encounter in a clinic. Mailing of an informational letter or packet without documentation of a subsequent telephone call or encounter to discuss transition is not sufficient documentation of a transition plan. Documentation must specifically reference transition, and must be documented by the 15th birthday.

Indicator Goal: The overall goal is that 100 percent of enrolled members sampled will have documentation of an initial transition plan by their 15th birthdays, since this is a CRS contractual requirement. A minimum of 80 percent of sampled youth having a documented transition plan will be acceptable.

Minimum Performance Standard: All CRS subontractors will be required to develop and implement interventions if results show performance below the minimum acceptable goal of 80 percent of youth having a documented transition plan by their 15th birthdays.

Data Collection Tool: A data abstraction tool will be utilized to review medical records submitted by the CRS Regional sites (see tool, Appendix A).

Data Source: Transition plans from medical records of sampled members, as submitted by the CRS Regional Clinics.

Data Collection: Review of transition plans from medical records of sampled members, as submitted by the CRS Regional Clinics. Review will be done by ADHS/CRS staff using a standardized data abstraction tool.

Confidentiality Plan: All member information is considered confidential and its security and privacy is protected. CRS will ensure that HIPAA and other applicable state and federal requirements are met, specifically:

- All forms, surveys, data disks, data CDs, and other communication formats that have member specific information will be stored in secure locations.
- All shared information will be in aggregate form with no identifiers that could be associated with an individual member.

Anecdotal information may be used but all identifiers that could be associated with an individual member will be excluded.

Data Validation/ Reliability: Multiple reviewers will each review a designated set of transition plans. The results of these reviews will be correlated for inter-rater reliability.

Denominator: The number of CRS members who turned 15 years of age on or between July 1, 2003, and June 30, 2004, and who were continuously enrolled in CRS for 12 months prior to and including their 15th birthdays, and were concurrently enrolled in AHCCCS.

Numerator: The number of members in the denominator who have a transition plan initiated and documented in the medical record by the 15th birthday.

Benchmark: CRS contracts require that transition planning is initiated and documented for enrolled members by age 14 years. The AAP, in conjunction with the American Academy of Family Physicians and the American College of Physicians-American Society of Internal Medicine has published a consensus statement that states youth with special health care needs should have adequate transition planning that starts at age 14 years.[7] Additionally, the MCHB has designated the provision of services necessary to make transitions to adult life as a core outcome in its national action plan to achieve community-based service systems for children with special health care

needs and their families.

Analysis, Intervention and Re-evaluation Plan:

CRS will calculate the total number of youth in the sample with documented transition plans by their 15th birthdays as a statewide aggregate and by CRS subontractor Site, as follows:

- Calculate the percentage of youth selected (N) who have documented transition plans during the study period from submitted CRS subontractor medical records (A), as a statewide aggregate and by CRS subontractor Site

$$\%\ \text{of children with documented transition plan initiated} = \frac{A}{N}$$

A = Documentation of transition plan included in the medical record
N = Selected youth

- Compare the percentages Statewide and by Regional Site with the desired goal. Cohen's effect size will be used to determine if the difference between the actual and goal proportions is significant [6]

Barriers will be analyzed, based on results of the baseline data gathered, as well as data obtained from focus groups with CRS staff and a survey of CRS members/families to ascertain their satisfaction with the transition planning process.

CRS will implement interventions to improve transition services and/or sustain adequate transition services based on analysis of results. Interventions will be developed for each identified barrier. Trend analysis will be conducted to measure the improvement over time.

Future goals will focus on standardization of the transition process and services among subontractor sites and incorporating best practices based on national guidelines, research, and quality tools, such as transition planning checklists, comprehensive resource sheets and educational services for youth and families. Additionally, CRS will focus specifically on coordination with schools in IEP development, and coordination with primary care providers. CRS also anticipates utilizing family/youth surveys and/or focus groups to ascertain the quality of transition services provided by CRS.

Comparative Analysis:

Comparison of percentages will be made:

- Between the goal and statewide results;
- Between the goal and subontractor results;
- Between subontractors; and,
- Between measurement years after a baseline is established.

CRS is not aware of any similar program or health plan with which to compare results.

Project Timelines:

By 10/1/05, ADHS/CRS will have established a baseline measurement from which to evaluate, will have proposed site-specific interventions, and will have proposed strategies to implement the interventions and evaluate post-implementation performance.

By 12/31/05, ADHS/CRS will have implemented the interventions.

By10/1/07, ADHS/CRS will complete a re-measurement of performance, will conduct an analysis to compare the baseline results with post-intervention data for the re-measurement

period (7/1/06-6/30/07), and will propose new interventions if goals are not met.

By 12/31/07, ADHS/CRS will implement new interventions, if necessary.

By 10/1/09, ADHS/CRS will undertake a second re-measurement and analyze results for the second re-measurement period (7/1/08-6/30/09).

If necessary, the cycle of development-analysis-evaluation will be repeated on a yearly basis until the statewide goal is reached.

Limitations: One limitation is that the project focuses only on the initiation of transition services, rather than the full range of services provided for all CRS-enrolled youth from age 14 to 21 years. Future plans include a qualitative analysis of transition services.

Report Format: The report will show results as an overall CRS percentage and also will show percentages by CRS Contractor site (see Appendix B). Barriers identified will be numbered and interventions will be documented to address each barrier. The intervention and evaluation summary format is also attached (see Appendix C). The report will be shared with appropriate ADHS/OCSHCN staff and CRS Contractors for the purpose of developing and implementing interventions. When applicable, information will be shared with the appropriate external entities to assist in further identification of interventions to improve transition services.

Definitions:

AAP:	American Academy of Pediatrics
ADHS:	Arizona Department of Health Services
CRS:	Children's Rehabilitative Services, a subdivision of ADHS. A section of the Office for Children with Special Health Care Needs whose mission is "to provide for medical treatment, rehabilitation, and related support services to medically and financially qualified individuals who have certain medical, disabling or potentially disabling conditions which have the potential for functional improvement."
CSHCN:	Children with Special Health Care Needs
Encounter:	A record of a medically related service rendered by a registered AHCCCS provider to an AHCCCS member enrolled with a capitated Contractor on the date of service
Enrolled:	Means an individual who has a CRS condition, has attended the first clinic visit, and has completed both the CRS financial interview and has signed a CRS payment agreement. An enrolled member is an individual who has been granted entry to the CRS program, and who is eligible to receive CRS services
HIPAA:	Health Insurance Portability and Accountability Act of 1996. Personal Health Information (PHI) for all members is protected in accordance with the privacy requirements in Code of Federal Regulations (CFR) Parts 160 and 164 Subparts A and E, to the extent that they are applicable.
IDEA:	Individuals with Disabilities Education Act-originated from the Education of the Handicapped Act, Public Law (P.L.) 94-142, which was passed by Congress in 1975, and amended by P.L. 99-457 in 1986 to ensure that all children with disabilities would have a free, appropriate public education available to them which would meet their unique needs. It was again amended in 1990 and the name was changed to IDEA.
IEP:	Individualized Educational Program, required for youth who receive services through IDEA
MCHB:	Maternal and Child Health Bureau
Member:	An individual who is enrolled in CRS and who is eligible to receive services from CRS providers.
NCHS:	National Center for Health Statistics
OCSHCN:	Office for Children with Special Health Care Needs. A section of the Arizona Department of Health Services whose mission is "to promote continuous improvement in the health, future and quality of life for adults and children with special health care needs by building partnerships with families, communities, and providers, both public and private".
Subcontractor:	A person contracted with ADHS to provide CRS Services.

SLAITS: The State and Local Area Telephone Survey is a broad-based, ongoing surveillance system available at the state and local levels for tracking and monitoring the health and well being of children and adults. The National Survey for children with special health care needs is conducted as a module of SLAITS.

Transition: Transitions, in general, are part of normal, healthy development and occur across the lifespan. Transition in health care for young adults with special health care needs is a dynamic, lifelong process that seeks to meet their individual needs as they move from childhood to adulthood.

References:

1. American Academy of Pediatrics, Committee on Children with Disabilities and Committee on Adolescence. Transition of Care Provided for Adolescents with Special Health Care Needs. *Pediatrics*. 1996; 98:1203-1206
2. Maternal and Child Health Bureau. *Achieving Success for All: Children and Youth With Special Health Care Needs. A 10-Year Action Plan to Accompany Healthy People 2010*. Washington, DC: Maternal and Child Health Bureau; 2001
3. Newacheck PW, Taylor WR. Childhood Chronic Illness: Prevalence, Severity, and Impact. *American Journal of Public Health* 1994;82:364-371
4. Blum RW. Transition to Adult Health Care: Setting the Stage. *Journal of Adolescent Health* 1995;17:3-5
5. www.hrtw.org
6. Cohen J. Statistical Power Analysis for the Behavioral Sciences. Lawrence Erlbaum Associates. Second Edition.1988
7. American Academy of Pediatrics. Improving Transition for Adolescents With Special Health Care Needs from Pediatric to Adult-Centered Health Care. *Pediatrics*. 2002 n.6;110; 1304-1306.

[END OF ATTACHMENT]

APPENDIX A: PERFORMANCE IMPROVEMENT MEDICAL RECORD DATA ABSTRACTION TOOL

Improving Pediatric-to-Adult Transition Services

Date of Review:	
CRS Member Name:	
CRS Member ID:	
CRS member DOB:	

Documentation of Transition Planning	**Yes**	**No**
Does the member have a documented transition plan? If yes, Record Date transition plan was initiated _____		
Was the transition planning process initiated by: (answer for all)		
Telephone call		
Clinic encounter		
If the transition plan was not initiated via telephone call or clinic encounter, is it documented that an informational packet or letter was sent? If yes, record date information/packet was sent _____		

[END OF APPENDIX]

APPENDIX B: PERFORMANCE IMPROVEMENT PROJECT RESULTS

Improving Pediatric-to-Adult Transition Services

Statewide Percentage Youth with Transition Plans by 15th birthday							
Measure Period	**Measurement**	**Numerator**	**Denominator**	**Finding**	**Benchmark**	**Goal**	**Significance**
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Northern Region Percentage of Youth with Transition Plans by 15th birthday							
Measure Period	**Measurement**	**Numerator**	**Denominator**	**Finding**	**Benchmark**	**Goal**	**Significance**
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Central Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	**Measurement**	**Numerator**	**Denominator**	**Finding**	**Benchmark**	**Goal**	**Significance**
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Southern Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	
Western Region Percentage Youth with Transition Plans by 15th birthday							
Measure Period	Measurement	Numerator	Denominator	Finding	Benchmark	Goal	Significance
7/1/03-6/30/04	Baseline				Contract requirement		Not Applicable
	Measurement 1					80%	
	Measurement 2					80%	

[END OF APPENDIX]

APPENDIX C: PERFORMANCE IMPROVEMENT PROJECT INTERVENTION AND EVALUATION SUMMARY FORMAT

Improving Pediatric-to-Adult Transition Services

Results Summary

Subontractor:	PIP: Improving Pediatric to Adult Transition Services for Youth
Goal: 80% of sampled youth with transition plan initiated by 15th birthday	Result:
Strengths:	

Action Plan

Barrier	Intervention	Action Steps	Target Date	Evaluation

[END OF APPENDIX]

ATTACHMENT J: RESERVED

ATTACHMENT K: COST SHARING COPAYMENTS

I. EXEMPT POPULATIONS (REGARDLESS OF RATE CODE)

The following populations are **exempt from copayments for ALL services ($0 copay):**

- All recipients under the age of 19, including all KidsCare members
- All Pregnant Women
- All ALTCS enrolled members
- All persons with Serious Mental Illness receiving RBHA services
- All recipients who are receiving CRS services
- SOBRA Family Planning Services Only members

Additionally, **no recipient** may be asked to make a copayment for family planning services or supplies.

II. STANDARD COPAYMENTS APPLY TO THE TITLE XIX WAIVER GROUP

Services to this population may <u>not</u> be denied for failure to pay copayment.

- Effective May 1, 2004, the standard copayments apply to the Title XIX Waiver Group, including RBHA General Mental Health and Substance Abuse service recipients. The standard copayments are as follows:

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	$ 0 per Rx
Brand Name Prescriptions when generic is available	$ 0
NON EMERGENCY USE OF ER	$ 5
Physician Office Visits	$ 1

III. STANDARD COPAYMENTS APPLY TO THE FOLLOWING POPULATIONS

Services to this population may <u>not</u> be denied for failure to pay copayment.

- AHCCCS for Families with Children
- Supplemental Security Income with and without Medicare

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	$ 0
Brand Name Prescriptions when generic is available	$ 0
Non Emergency Use of ER	$ 5
Physician Office Visits	$ 1

IV. OTHER CO-PAYS

HIFA Parents (Parents of KidsCare and SOBRA Children)

- Copayment is not mandatory
- **EXCEPTION: Native American Health Plan Enrolled Parents are exempt from any copayment**

Service	Copayment
Generic Prescriptions or Brand Name if generic not available	$ 0
Brand Name Prescriptions when generic is available	$ 0
Non Emergency Use of ER	$ 5
Physician Office Visits	$ 0